

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE RECOMMENDATIONS
RELATED TO THE FISCAL YEAR 1988
BUDGET RESOLUTION RECONCILIATION
INSTRUCTIONS



JULY 21, 1987

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SUBCOMMITTEE RECOMMENDATIONS RELATED TO THE FISCAL YEAR 1988 BUDGET RESOLUTION RECONCILIATION INSTRUCTIONS

SUMMARY OF OUTLAY AND REVENUE PROVISIONS AS RECOMMENDED
BY THE SUBCOMMITTEES OF WAYS AND MEANS
RELATED TO THE REQUIREMENTS OF THE FISCAL YEAR 1988 BUDGET RESOLUTION

(By fiscal year, in millions of dollars)

	1988	1989	1990	3 YR TOTAL
A. <u>Budget Resolution Targets</u>				
Outlays	-1,600	-3,150	-4,450	-9,200
Revenues	-19,300	-22,000	-23,000	-64,300
Total	-20,900	-25,150	-27,450	-73,500
B. <u>Subcommittee Recommendations</u>				
Trade				
Outlays	0	0	0	0
Public Assistance				
Outlays	7	12	14	33
Social Security				
Outlays	22	54	7	83
Revenues	-331	-437	-458	-1,226
Oversight				
Outlays	-436	-327	-285	-1,048
Revenues	37	60	54	151
Medicare				
Outlays	-1,553	-2,985	-4,330	-8,868
Total Subcommittee	-2,254	-3,623	-4,998	-10,875
C. <u>Reported and Other Bills</u>				
Medicare catastrophic (w/ drug amendment)	-396	-1,138	-503	-2,037
Welfare reform (H.R. 1720)	58	338	1,022	1,418
Total Reported Bills	-338	-800	549	-619
D. <u>Additional Revenue Needed to Achieve Instructions</u>	-18,308	-20,727	-22,971	-62,006

NOTE: Sign indicates impact upon the deficit.

OUTLAY AND REVENUE PROVISIONS AS RECOMMENDED BY
THE SUBCOMMITTEES OF WAYS AND MEANS

(By fiscal year, in millions of dollars)

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-YEAR TOTAL</u>
A. Trade				
(Outlays)				
Authorization of Customs Service and USTR	0	0	0	0
Subtotal	0	0	0	0
B. Public Assistance				
(Outlays)				
1. Miscellaneous SSI and AFDC amendments	1	1	1	4
2. Foster care and child welfare amendments	0	0	0	0
3. Effective date of work search requirement	0	0	0	0
4. Continuation of benefits for temporarily institutionalized	--	2	2	4
5. Deem certain widow(er)s SSI recipients	3	6	8	16
6. Mother/infant foster care programs	3	3	3	9
Subtotal	7	12	14	33
C. Social Security				
(Revenues)				
1. Extend FICA tax to inactive duty earnings	-148	-194	-203	-545
2. Treatment of group-term life insurance wages under FICA	-39	-61	-72	-172
3. Increase Railroad Retirement tier II tax rate	-144	-182	-183	-509
Subtotal	-331	-437	-458	-1,226
(Outlays)				
4. Attorneys' fees	0	0	0	0
5. Pension offset loophole	-1	-3	-6	-10
6. Treat corporate directors as employees	--	--	--	--
7. Modify retirement test for the year worker dies	--	--	--	--
8. Denial of benefits to Nazi war criminals	--	--	--	--
9. Clarify terms of appointment for public members of Board of Trustees	0	0	0	0
10. Modify voluntary coverage between Iowa and HHS	--	--	--	--
11. Restoration of windfall benefits	1	1	1	3

C. Social Security (cont.)

12. Continue disability benefits during appeal	20	50	5	75
13. Lengthen extended period of eligibility for disability	1	5	6	12
14. Interim benefits in cases of delay	1	1	1	3
	-----	-----	-----	-----
Subtotal	22	54	7	83

D. Oversight

(Revenues)

1. Reform of defined benefit plan requirements	37	60	54	151
	-----	-----	-----	-----
Subtotal	37	60	54	151

(Outlays)

2. PBGC variable rate premium	-436	-327	-285	-1,048
3. Lobbying and political activities	--	--	--	--
	-----	-----	-----	-----
Subtotal	-436	-327	-285	-1,048

E. Medicare

(Outlays)

1. Set hospital update factor and increase payments for burn DRGs	-730	-2,400	-3,150	-6,280
2. Set rural hospital update	40	50	50	140
3. Reduce capital-related payments	-70	0	-585	-655
4. Develop hospital reporting system	0	0	0	0
5. Raise threshold for prospective payment for SNFs	0	0	60	60
6. Reform standards for SNFs	0	30	45	75
7. Miscellaneous Part A provisions	0	0	0	0
8. Set average prompt-pay standard	-480	-220	-280	-980
9. Eliminate return-on-equity to outpatient departments and proprietary SNFs	-55	-60	-65	-180
10. Requirements for HMO and capitation demonstration projects	0	0	0	0
11. Miscellaneous Parts A and B provisions	0	0	0	0
12. Set update for physician payment	-120	-190	-230	-540
13. Reduce payments for overpriced procedures	-85	-165	-175	-425
14. Limit payments for A-scan procedures	-28	-45	-50	-123
15. Prospective payments system for RAPS	0	0	0	0
16. Prohibit charges for purchased services	-5	-10	-10	-25
17. Requirement for unassigned claims forms	0	60	100	160
18. Offer simplified billing arrangement	0	0	0	0
19. Provide coverage of therapeutic footwear for diabetics	-20	-35	-40	-95
20. Miscellaneous Part B provisions	0	0	0	0
21. Encourage voluntary insurance risk pools	0	0	0	0
	-----	-----	-----	-----
Subtotal	-1,553	-2,985	-4,330	-8,868

TOTAL -2,254 -3,623 -4,998 -10,875

NOTE: Sign indicates impact upon the deficit.

-- Negligible.

RECOMMENDATIONS OF THE SUBCOMMITTEE ON TRADE

1. AUTHORIZATION OF APPROPRIATIONS FOR FY 1988 AND FY 1989 FOR U.S. CUSTOMS SERVICE, ITC, AND USTR

Present Law

The level of appropriations for fiscal year 1987 under which these agencies are currently operating is as follows:

U.S. Customs Service - \$1,019,435,000 (of which \$170,950,000 is for the operation and maintenance of the air program)

U.S. International Trade Commission (ITC) - \$33,900,000

U.S. Trade Representative (USTR) - \$13,300,000

Explanation of Provision

The draft bill ordered favorably reported by the Subcommittee on Trade on June 18 combines authorizations of appropriations for fiscal years 1988 and 1989 for Customs, ITC, and USTR as follows:

U.S. Customs -- The draft bill authorizes appropriations of \$1,018,501,000 for fiscal year 1988 and \$1,138,752,000 for fiscal year 1989. The draft bill authorizes non-commercial operations at a FY 1988 level of \$348,192,000 and \$381,819,000 for FY 1989. For commercial operations \$615,000,000 is authorized for FY 1988 and \$630,865,000 for FY 1989. The draft bill further provides that \$118,309,000 is authorized for operations and maintenance of the air interdiction program, with \$126,068,000 for the program in FY 1989.

ITC -- The draft bill authorizes appropriations of \$35,386,000 for FY 1988, and \$36,730,000 for FY 1989.

USTR -- The draft bill authorizes appropriations of \$15,141,000 for FY 1988 and \$15,514,000 for FY 1989.

Effective Date

These provisions would be effective beginning October 1, 1987.

Budget Effect

The Committee is not scored for authorization bills made under the reconciliation process.

RECOMMENDATIONS OF THE SUBCOMMITTEE ON PUBLIC ASSISTANCE
AND UNEMPLOYMENT COMPENSATION

1. MISCELLANEOUS SSI and AFDC AMENDMENTS

a. Disregard of In-Kind Assistance in AFDC and SSI

Present Law

In-kind assistance provided by a private non-profit organization to SSI recipients must be disregarded if the State has determined that the assistance is provided on the basis of need. States may, at their option, disregard in-kind assistance provided to AFDC recipients. The authority for these disregards was created by the Deficit Reduction Act of 1984 and expires on September 30, 1987.

Explanation of Provision

Permanently extend the AFDC and SSI disregards of such in-kind assistance.

Effective Date

October 1, 1987

b. Enhanced Federal Funds for AFDC Fraud Control

Present Law

States are reimbursed with 50 percent Federal funds for the proper and efficient administration of the AFDC program. This includes the cost of any fraud control activities.

Explanation of Provision

Authorize Federal funding of 75 percent for the costs of fraud control activities. States electing to use these funds could apply them to the investigation, prosecution, enforcement, or administrative hearing of intentional program violations of the AFDC program.

The determination of an intentional violation would be based on proof of intentionally: (a) making a false or misleading statement; (b) misrepresenting, concealing, or withholding facts; or (c) committing any act that is a violation of the AFDC program, the State's AFDC plan, or any other provision of Federal or State law or regulations relating to the AFDC program.

Recipients found to have committed an intentional program violation would be ineligible to participate in the AFDC program for a period of six months for the first offense and twelve months for the second offense. The third offense would result in permanent ineligibility.

The determination of an intentional program violation could be made either through an administrative hearing or by the decision of a court. Any action by the State agency to terminate or reduce benefits first would follow the established notice and fair hearing process within the AFDC program. The State agency could combine hearings for violations that have occurred in the AFDC and food stamp programs when the factual issues arise from the same or related circumstances.

Effective Date

October 1, 1987

c. Exclusion of Certain Real Property

Present Law

Under current law the Secretary of HHS must count toward the asset limit real property which is not specifically excluded. If an SSI applicant or recipient has real property which is not excluded from the asset limit, and the excess resources make the individual ineligible for SSI, "conditional SSI benefits" can be provided to the individual while an effort is made to sell the property. The amount of the "conditional SSI benefits" paid out during this period are considered overpayments and the SSI recipient is required to repay these benefits after the resource has been sold. Under current regulations, conditional payments can be made only if the excess total resources do not exceed \$3,000 for an individual and \$4,500 for a couple. The regulations provide that conditional payments can be made for up to six months in the case of real property.

Explanation of Provision

Provides that real property which is owned by an SSI recipient would not be counted as a resource when it cannot be sold. This policy would apply under 3 circumstances: (1) the property is jointly owned (and its sale would cause undue hardship (including loss of housing) for the other owners of such property); (2) the sale is barred by a legal impediment; or (3) the owner's reasonable efforts to sell it have been unsuccessful.

Effective Date

October 1, 1987

d. Adjustment of Penalty for Transfer of Assets

Present Law

Individuals who transfer assets at less than fair market value are generally ineligible for SSI for two years. An individual who gives away or sells a nonexcludable resource for less than fair market value which has the effect of making the individual eligible for SSI has the uncompensated value of that resource counted toward the SSI countable resources limit. The current limit is \$1,800 for an individual and \$2,700 for a couple. The period of ineligibility extends for a period of 24 months from the date of transfer. The uncompensated value is the difference between fair market value at the time of transfer and the amount received for the resource. Any amount of resources given away, even if they cannot be recovered by the SSI applicant, will trigger the penalty.

Explanation of Provision

The amendment would provide that the amount of the total uncompensated value of resources given or sold would not be counted toward the SSI countable resources limit until the cumulative uncompensated value of the resources exceeds \$3,000. In addition, in cases where there would otherwise be a denial of benefits, the Secretary would have the authority to suspend the application of the penalty if the Secretary determines that such suspension is necessary to avoid undue hardship.

Effective Date

October 1, 1987

e. Exclusion of Interest on Burial Accounts

Present Law

Current law allows an individual to exclude up to \$1,500 in a separately identifiable burial account if inclusion would cause the individual to exceed the resource limit. For individuals with less than \$1,800 in resources, including a burial account, interest earned on the burial account is countable. For individuals with combined resources, including a burial account, in excess of \$1,800, interest earned on the burial account, that exceeds the \$1,800 resource limit, is not counted.

Explanation of Provision

Provides that interest earned on the entire value of a separately identifiable burial account owned by an SSI recipient would be excluded, regardless of the individual's other resources.

Effective Date

October 1, 1987

f. Disregard of AFDC Benefits Under SSI Retrospective Accounting

Present Law

An individual cannot be eligible for both AFDC and SSI in the same month. SSI eligibility is determined retrospectively, using income and circumstances in the month prior to application. This results in AFDC benefits being counted as income, even though these benefits are not received in the month of application for SSI.

Explanation of Provision

Provides that AFDC benefits received by an individual applying for SSI would not be counted in determining eligibility for or amount of SSI benefits. The amendment would result in not counting federally matched AFDC payments for SSI purposes as is now the case for State and local financed general assistance or other State or local assistance which is based on need.

Effective Date

October 1, 1987

g. Technical Amendment Relating to Certain Couples in Medical Institutions

Present Law

A State, at its option, may waive the SSI rule that considers members of a couple sharing a room in a medical institution as two eligible SSI individuals instead of an SSI couple if such a rule would disadvantage either member of a couple in determining eligibility under other State programs or under the Social Security Act. This provision was enacted in 1986 as part of P.L. 99-643.

Explanation of Provision

Allows for the State option to apply if the members of the couple are living in the same medical institution, not just when they are living in the same room.

Effective Date

November 10, 1986

h. Extension of Deadline to Apply for Medicaid Protection

Present Law

Low-income widows and widowers who lost eligibility for SSI because of the 1984 social security law's disability benefit increase have until July 1, 1987 to file an application with the State for protection against loss of Medicaid eligibility.

Explanation of Provision

Extends the deadline to July 1, 1988.

Effective Date

July 1, 1987

i. Increased Emergency Advance Payments

Present Law

An individual who is presumptively eligible for SSI may receive a maximum of \$100 in the form of emergency advance payments.

Explanation of Provision

Provides for an increase in the amount of emergency advance payments which can be paid directly by a Social Security district office to those in need of immediate subsistence income. Instead of a maximum of \$100, the maximum would equal the regular monthly SSI benefit standard plus, if any, the State supplementary payment.

Effective Date

October 1, 1987

j. Modification of Interim Assistance Reimbursement

Present Law

Under current law, a State is reimbursed from a retroactive SSI payment if the State has provided emergency assistance to an SSI applicant prior to receipt of retroactive SSI benefits.

Explanation of Provision

Permits the interim assistance reimbursement program to also be used in cases where the State has provided cash assistance to SSI recipients whose SSI benefits were terminated or suspended and who are subsequently found eligible for benefits. It would also include the use of the interim assistance mechanism when the recipient's check has been lost or stolen and there has not been a prompt replacement.

Effective Date

October 1, 1987

k. Special Notice to Blind Recipients

Present Law

No provision.

Explanation of Provision

Requires that the Social Security Administration provide applicants and recipients who are blind with the option to receive a supplementary notice, such as by telephone or certified letter, of any decision, determination or other action taken or proposed to be taken with respect to his or her rights under the SSI program.

Effective Date

October 1, 1987

1. Technical Amendment Related to Rehabilitation Services to the Blind

Present Law

Disabled SSI recipients are allowed to continue vocational rehabilitation services funded under the SSI program, even if there is an improvement in their medical condition that results in their no longer qualifying for SSI.

Explanation of Provision

Provides that blind persons receiving benefits under the SSI program would be allowed, as is now the case for disabled SSI recipients, to continue to receive vocational rehabilitation services funded under the SSI program even if there is an improvement in their medical condition that results in their no longer qualifying for SSI benefits.

Effective Date

October 1, 1987

2. Extension of the Length of Time that an Individual in a Public Emergency Shelter Can be Eligible for SSI.

Present Law

Residents of public institutions generally are not eligible for SSI. However, SSI benefits are paid for up to 3 months to an otherwise eligible individual in a public emergency shelter.

Explanation of Provision

Extends SSI benefits for up to 12 consecutive months to otherwise eligible individuals in a public emergency shelter.

Effective Date

October 1, 1987

n. Temporary Increase in Duration of Disregard for
Retroactive Payments

Present Law

Retroactive SSI or social security payments are disregarded as a resource for six months.

Explanation of Provision

Provides that, for the 2-year period beginning January 1, 1987, retroactive SSI and social security payments would be disregarded as a resource for 12 months.

It is expected that many disabled individuals will be entitled to substantial back awards once the Social Security Administration (SSA) issues decisions in their cases under the 1984 Disability Benefits Reform Act. This amendment would disregard retroactive payments as a resource for 12 months to allow SSI recipients some time to determine how best to use the funds before they will be counted as a resource. Because it is anticipated that SSA will issue these determinations in the near future, this provision would be limited to those individuals that receive their back awards in 1987 or 1988.

Effective Date

January 1, 1987

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
1	1	1	4

2. FOSTER CARE AND CHILD WELFARE AMENDMENTS

a. Extension of Federal Matching Funds for Voluntarily Placed Foster Care ChildrenPresent Law

Federal matching funds are available for children placed in foster care under a voluntary placement agreement if the State has met certain requirements for foster care services and program reviews. Specifically, States must establish a foster care information system and a case plan and case review system as well as provide preplacement preventive services and reunification services. The voluntary placement provision is designed to give parents the opportunity to ask for help rather than having a court order the child into foster care. This authority expires on September 30, 1987.

Explanation of Provision

Permanently extend the authority for Federal matching funds for voluntarily-placed foster care children under the same terms and conditions as apply currently.

Effective Date

October 1, 1987

b. Foster Care Ceiling and Transfer AuthorityPresent Law

State-by-State ceilings are placed on foster care funds whenever the Federal appropriation for child welfare services exceeds \$266 million. This ceiling is intended to create financial incentives for States to reduce unnecessary placement or extended placement in foster care.

A State may use any one of the following methods to calculate the most favorable ceiling: (1) the State's fiscal year 1978 Federal foster care funds increased by 33 1/3 percent for fiscal year 1981, and increased thereafter by twice the increase in the CPI each year but not to exceed 10 percent each year; (2) the State's share of \$100 million relative to its population under 18; or (3) for those States with foster care caseloads below the national average, the State's funds increased by a percent equal to its caseload growth but not more than 10 percent, plus the increase provided in (1).

In the absence of a mandatory ceiling, States may elect to operate under a voluntary ceiling. Whenever a ceiling is in effect -- be it voluntary or mandatory -- a State may transfer all or a portion of unused foster care maintenance funds to child welfare services. Before electing a voluntary ceiling, a State must have implemented certain foster care services and procedures. These are: (1) a foster care information system; (2) preplacement preventive services; (3) a case plan and case review system; and (4) reunification services.

The foster care ceilings and the transfer authority expire on September 30, 1987.

Explanation of Provision

Extend the foster care ceilings and the transfer authority for two years, through September 30, 1989.

Effective Date

October 1, 1987

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
0	0	0	0

3. EFFECTIVE DATE OF THE WORK SEARCH REQUIREMENT FOR CERTAIN UNEMPLOYMENT BENEFITS

Present Law

The Extended Benefits (EB) program is financed equally by the Federal government and the States. The Omnibus Reconciliation Act of 1980 (P.L. 96-499) amended the EB program to establish new disqualification requirements for EB claimants relating to: (1) failure to accept offers or referrals to suitable work; (2) actively seeking work; and (3) duration of disqualifications applicable to EB claimants. The provisions were effective for weeks beginning after March 31, 1981. The usual language permitting a delayed effective date for States requiring State legislative action was not included. Federal audits of the EB program may result in the disallowance of Federal funds for up to 16 States that did not implement the requirement by April 1.

Explanation of Provision

Change the effective date for the purpose of determining the Federal matching grant only from weeks of unemployment beginning after March 31, 1981 to October 31, 1981, except for any State whose legislature did not meet in 1981, in which case the effective date would be for weeks of unemployment beginning after October 31, 1982.

Effective Date

On enactment.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
0	0	0	0

4. CONTINUATION OF BENEFITS FOR INDIVIDUALS TEMPORARILY
INSTITUTIONALIZED (Section 102 of H.R. 2795)

Present Law

An individual who is a resident of a public institution throughout a month is not eligible for SSI unless it is a Medicaid facility, a community-based residence serving no more than 16 persons or an emergency shelter (but not for more than 3 months care for an individual in any 12 month period.)

When an individual enters a hospital, extended care facility, nursing home or intermediate care facility in which a major portion of the cost is paid by the Medicaid program, their monthly SSI benefit standard is reduced to \$25 beginning with the first full calendar month the individual is in the institution.

Individuals whose income from non-SSI sources exceeds the \$25 benefit standard, are not eligible for an SSI payment. This includes those who previously, when they were not living in a medical institution, were receiving some SSI because their social security benefits were less than the regular SSI benefit standard in that State.

Medicaid regulations require States to allow such individuals to retain no less than \$25 a month of their income as a "personal needs allowance" when their income is applied along with Medicaid reimbursement, to pay for their institutional medical care. States have the option under present Medicaid regulations to allow such an individual to retain more than \$25 a month if the State determines that it is needed to maintain a home to return to after an expected temporary stay in the Medicaid institution. The regulations require that a physician must have certified that the stay is expected to last no more than six months. The retention of the extra funds for the home maintenance cannot last more than six months.

Explanation of Provision

Provides that any SSI recipient without non-SSI income who enters a Medicaid institution or public institution would not have their benefits reduced to the \$25 a month standard (or terminated in the case of a public institution) if their stay is expected to be of a temporary nature and they need to maintain a living arrangement to return to after release. Full benefits, including State supplementation, would continue for 3 months. The benefit level would equal that paid in the month prior to the month the individual entered an institution. HHS could enter into agreements with public or private agencies to help determine those individuals to whom this provision would apply.

Effective Date

July 1, 1988

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
*	2	2	4

5. CERTAIN DISABLED WIDOWS AND WIDOWERS DEEMED SSI RECIPIENTS

Present Law

SSI law requires that an individual apply for all other benefits for which he or she is eligible. Thus, at age 60, disabled widows (or widowers) who apply for or are receiving SSI, are required to apply for early aged widow or widower social security benefits. (These benefits are actuarially reduced.) In cases where the resulting social security benefit is sufficient to preclude further SSI eligibility, the disabled widow or widower loses Medicaid coverage. These individuals generally do not qualify for Medicare benefits until age 65. In this case, a proportionately small increase in cash income can result in the loss of far more valuable medical coverage.

Explanation of Provision

The amendment provides that an individual who would otherwise qualify for SSI on the basis of disability or blindness but beginning at age 60 qualifies for social security early aged widow's or widower's benefits and loses eligibility for SSI, would, nevertheless, be deemed to be an SSI recipient for purposes of eligibility for Medicaid. Eligibility for Medicaid would continue until such time that the individual becomes eligible for Medicare as a social security retiree or if earlier, on the basis of being eligible for social security disability benefits.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
3	6	8	16

6. MOTHER/INFANT FOSTER CARE PROGRAMS

Present Law

Federal matching funds under Title IV-E of the Social Security Act are provided to States for foster care maintenance payments for children placed in foster care when they have been removed from their home as a result of a judicial determination. The court must find that continuing to live in that home would be contrary to the welfare of that child. Also, children placed in foster care under a voluntary placement agreement between the agency and the parent are also eligible for Federal foster care maintenance payments.

In some teenage foster care cases, the foster child is herself the parent of an infant child who lives in the same foster family home or a specialized residential program for teen mothers and their infants. The infant child of a foster child living in the same foster care home or institution as the infant's mother, is not eligible for Federally assisted foster care. This is because the infant technically has not been removed from the home of the parent and placed in foster care. This is the case even though the care of the infant may be largely the responsibility of the foster care provider. Such children of foster care children may be eligible as a child-only AFDC unit but at a payment level much less than the cost of specialized foster care programs for foster care teenagers and their infants.

Explanation of Provision

The amendment would require States to include in the foster care payment an amount equal to the rate payable for the foster care teenage mother plus the foster care rate payable for the infant child in their own right in the same foster care setting.

While such infants would not be directly eligible for foster care, the amendment would deem them to be Title IV-E foster care children for purposes of Medicaid eligibility. If the infant is later adopted, the infant would also be deemed to have been a Title IV-E foster care child for purposes of eligibility under the Title IV-E adoption assistance program.

The fact that the teenage mother of the infant has been removed from her home and placed in foster care indicates a high probability of risk for the infant and the need for specialized foster care. Such specialized foster care includes: teaching the young mother in foster care how to care for and nurture her child; evaluating her capability to assume increasing responsibility for parenting her child; and helping her to make decisions related to long range efforts to become self-sufficient. Such specialized foster care is also intended to prevent a situation where, because of the teenager's own parenting limitations, there may be the need for foster care for her child. Prevention of still another generation of dependency is a primary objective of specialized foster care for teenage foster care girls and their infants.

Effective Date

October 1, 1987

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
3	3	3	9

RECOMMENDATIONS OF THE SUBCOMMITTEE ON SOCIAL SECURITY

1. EXTEND FICA TAX TO INACTIVE DUTY EARNINGS OF MILITARY RESERVISTS AND CERTAIN OTHER EARNINGS

Present Law

Under present law, certain forms of earnings paid to employees are exempt from FICA taxes. These earnings include:

Armed Forces Reservists -- Approximately 1.4 million Armed Forces reservists do not receive Social Security credit and are not subject to Social Security taxes for their inactive duty earnings, because "inactive duty training" (generally, weekend training drill sessions) has not been included as covered employment under the law. Earnings from full time active duty or from "active duty for training" (training sessions lasting several weeks) constitute covered employment under current law.

Agricultural Workers -- Under present law, cash remuneration paid to an employee in any taxable year for agricultural labor is excluded from the definition of wages unless the employee receives more than \$150 during the year for such labor or the employee works for the employer more than 20 days during the year.

Individual Aged 18-21 -- Services performed by individuals under age 21 who are employed by their parents, even if employed in the parent's trade or business, do not currently constitute covered employment.

Spouses -- Services performed by an individual in the employ of his spouse do not constitute covered employment.

Explanation of Provision

The provision extends coverage under social security to services performed by reservists in "active duty training;" to services performed by individuals aged 18-21 working for their parents in a trade or business; and to services performed by an individual in the employ of his or her spouse's trade or business. The provision also requires, with respect to agricultural labor, that: (a) any remuneration for agricultural labor paid by an employer to an employee constitute wages if the employer pays more than \$2,500 to all employees for such labor during the taxable year, (b) the \$150 annual cash pay test would continue to be applied if the \$2,500 annual payroll test is not met, and (c) the 20-day test would be eliminated.

Effective Date

These proposals would be effective January 1, 1988.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
-148	-194	-203	-545

2. TREATMENT OF GROUP-TERM LIFE INSURANCE WAGES UNDER FICA

Present Law

The cost of group-term life insurance provided by an employer to an employee is excluded from the definition of wages for purposes of the FICA tax.

For income tax purposes, the cost of employer-provided group-term life insurance is includible in an employee's gross income to the extent that the coverage exceeds \$50,000. Additionally, employer-provided group-term life insurance is included in an employee's gross income if the coverage is provided on a discriminatory basis.

Explanation of Provision

The provision includes the cost of employer-provided group term life insurance in wages for FICA tax purposes if such insurance is includible in gross income for income tax purposes.

Effective Date

This proposal would be effective January 1, 1988.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
-39	-61	-72	-172

3. RAILROAD RETIREMENT TIER II TAX INCREASE

Present Law

The primary source of income to the railroad retirement account is payroll taxes levied on covered employers and their employees. Currently, both employers and employees pay a Tier I tax which is equivalent to the social security tax rate. In addition, a Tier II tax is paid by both rail employers and employees. These taxes are applied to compensation paid to employees, up to the maximum annual amount. Under present law, the Tier II tax rate is 14.75 percent for employers and 4.25 percent for employees. The Tier II wage base in 1987 is \$32,700.

Explanation of Provision

The provision increases the railroad retirement Tier II taxes by 2.0 percentage points, effective January 1, 1988. The provision would divide the 2.0 percentage point increase so as to increase employer contributions by 1.35 percentage points and employee contributions by 0.65 percentage points, respectively.

Additionally, the provision establishes a 7 member Commission on Railroad Retirement Reform to study alternative methods of securing the long-term viability of railroad retirement. The President would appoint three members, one of whom would represent rail labor, one of whom would represent rail management, and one of whom would represent the general public. The President pro tempore of the Senate would appoint two public members after consultation with the Chairman of the Senate Committee on Labor and Human Resources and the Chairman of the Senate Committee on Finance. The Speaker of the House of Representatives would appoint two public members after consultation with the Chairman of the House Committee on Ways and Means and the Chairman of the House Committee on Energy and Commerce. The Commission would submit its findings to Congress by October 1, 1989.

Effective Date

The provision would be effective January 1, 1988.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
-144	-182	-183	-509

4. ATTORNEYS' FEES

Present Law

Attorneys representing social security claimants may petition for a fee of up to 25 percent of the past due benefits to which the claimant is entitled. Under current procedures, the attorney must petition for this amount; the ALJ deciding the case reviews the fee petition, and, if the amount is under \$1,500, may award the fee at that point. If the amount of the fee is over \$1,500, the petition must be sent to the regional ALJ office for review. In cases where the beneficiary's back award is subject to offset for repayment of SSI benefits or to the worker's compensation offset, SSA's current policy is to apply the offset before paying the attorney fee, so that in most cases there are no funds left to pay the attorney.

Explanation of Provision

The provision eliminates the fee petition process for most cases, and establishes in its place an automatic fee payment procedure under which attorneys would automatically be paid 25 percent of the back award due the claimant, up to a cap of \$4,000, indexed to the social security COLA. This amount would be paid by SSA at the time the back award is paid to the beneficiary, if no challenge to the size of the fee is filed by then by the ALJ in the case, or by the claimant. The payment would be made in the form of a two-party check payable to the attorney and the claimant for the full amount of the back award, accompanied by a notice from SSA setting forth the amount due the attorney and the claimant and an affidavit as to the proper division of the back award to be sworn to by the attorney and the claimant and returned to SSA. In cases of a protest by the client or the ALJ, or where the attorney wished to be paid more than the \$4,000 cap amount, the attorney would file a petition supporting the fee request, with review by the individual ALJ reviewing the case where the claimant is protesting or where the attorney is requesting a higher fee, and by the regional office where the ALJ is protesting.

The decision-maker in the case, usually the ALJ, must be notified by SSA by the time of the hearing as to the approximate amount of the beneficiary's back award and of the attorney fee to be paid. The decisionmaker must relay this information to the claimant and the attorney at the time of the hearing. The attorney may waive the fee altogether, in which case the claimant would receive the full back award check. The ALJ must protect the amount of the award within 10 days of the hearing, through notice to the regional ALJ office.

In cases of continuing entitlement to benefits, where payments have continued through the appeal process and either no back award, or one covering only the period after the ALJ hearing, is due, the attorney would be granted an award of 25 percent of the total of benefits paid through the period of appeal. This amount would constitute an "overpayment" on the beneficiary's account, which would then be repaid by the beneficiary at a rate of 10 percent of the benefit each month. Where no benefits accrue per se (e.g. representative payee disputes, Medicare eligibility, disputes over the existence of overpayments, etc.), the fee would be set at an amount not to exceed three times the basic monthly benefit amount (PIA), or if less, three times the monthly benefit amount (in cases of reduced PIA benefits such as disabled widows or disabled adult children). This amount will be paid through the overpayment procedure described above, and may be disputed by either the ALJ or the claimant.

In all cases where Title II social security benefits are due, the 25 percent attorneys' fee would be calculated based on the gross amount of the back award before applying any offsets to the back award, and no further offset is to be applied to the beneficiary's monthly benefit.

Effective Date

The provision would be effective for decisions rendered on or after January 1, 1988.

Budget Effect

None.

5. GOVERNMENT PENSION OFFSET LOOPHOLE

Present Law

Under the government pension offset, spouse's and surviving spouse's benefits received by a worker based on his or her spouse's social security covered work are reduced by two-thirds of the amount of any government pension to which a person is entitled based on his or her own work in a federal, state or local government job not covered under social security.

The treatment of government workers under the government pension offset is similar to the treatment of workers in social security covered employment. In social security covered employment, the total amount of benefits which can be received by a worker who is eligible to receive both a spouse's benefit or a surviving spouse's benefit and a worker's benefit based on his or her own social security covered work is limited to the greater of the two benefits. In effect, the spouse's benefit is offset by the worker's benefit and only the excess, if any, is paid in addition to the worker's benefit.

Those pensions based on government employment which is covered by social security are exempt from the government pension offset, since workers covered by social security are already subject to the offset of social security spouse's and survivors spouse's benefits described above. The Social Security Act therefore provides that the offset does not apply to pensions based on government employment which is covered under social security on the last day of the person's employment. The purpose of this "last day" rule is to relieve from the government pension offset employees in those state and local governments which voluntarily agree to cover a group of or all of their employees under social security.

The Federal Employees' Retirement System Act of 1986 (FERS) established a new retirement system which includes social security coverage for federal employees. Under this new system, those employees currently covered by the Civil Service Retirement System (CSRS) will be given the opportunity from July 1, 1987 to December 31, 1987 to make a one-time election to join FERS and obtain social security coverage.

The unintended interaction of the new FERS program and the "last day" rule permit an individual to avoid the government pension offset and receive both a full government pension and a full spouse's or surviving spouse's benefit. By switching to FERS for just one day prior to retirement, the individual is able to meet the last day rule and escape the pension offset.

Explanation of Provision

A federal employee would be exempt from the government pension offset if he or she has 5 years of federal employment covered by social security after June 30, 1987.

A transition would be provided for those who are near retirement. Persons who are 65 or over during CY 1987 will be exempt from the government pension offset if they have 6 months of social security covered federal employment; those turning 65 in CY 1988 will be exempt with 1 year of social security covered federal employment; those turning 65 in CY 1989 will be exempt with 2 years; those turning 65 in CY 1990 will be exempt with 3 years; those turning 65 in CY 1991 will be exempt with 4 years; and those turning 65 in CY 1992 and thereafter will be exempt with 5 years.

Effective Date

The provision would be effective for federal employees who join FERS on or after June 30, 1987.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
-1	-3	-6	-10

6. TREAT CORPORATE DIRECTORS AS EMPLOYEES FOR FICA TAX PURPOSES

Present Law

At present, fees paid to directors of corporations for their services are taxable under social security as self-employment income. Corporate directors are not considered employees of the corporation for social security employment tax purposes. This treatment allows directors of corporations to defer receipt of a substantial fraction of their director fees until after they attain the age of 70 as a way of avoiding the retirement test under social security and delaying the payment of taxes on fee income.

Explanation of Provision

The provision would treat directors of corporations as employees solely for FICA tax purposes.

Effective Date

This proposal would be effective January 1, 1988.

Budget Effect

Negligible.

7. MODIFY THE RETIREMENT TEST FOR THE YEAR IN WHICH A WORKER DIES

Present Law

Under current law, any beneficiary under age 70 with earnings in excess of certain thresholds (in 1987, \$6,000 annually for those under 65, \$8,160 for those over 65) receives a \$1 reduction in benefits for every \$2 earned over the annual threshold. If an individual dies in the middle of the year, the annual exempt amount is prorated accordingly. Further, in the case of a beneficiary who dies in the month prior to the month he or she attains age 65, the lower threshold level applies. This may cause a beneficiary who reasonably expects to live until the end of the year, or reach age 65 during the year, to be subject to either the prorated threshold or the lower threshold.

Explanation of Provision

The provision allows beneficiaries to earn the full annual exempt amount in the year of death and to be subject to the higher annual exempt amount if they die before they reach age 65 in the year they would otherwise have attained age 65.

Effective Date

The provision is effective upon enactment.

Budget Effect

Negligible.

8. DENIAL OF BENEFITS TO INDIVIDUALS DEPORTED OR ORDERED DEPORTED ON THE BASIS OF ASSOCIATIONS WITH THE NAZI GOVERNMENT OF GERMANY DURING WORLD WAR II

Present Law

Section 202(n)(1) of the Social Security Act provides for the suspension of benefits due to the deportation of a worker beginning with the month after the month in which the Secretary of Health and Human Services is notified by the Attorney General that the individual has been deported under various paragraphs of section 241(a) of the Immigration and Nationality Act. However, section 202(n)(1) does not apply to individuals who have been deported on account of certain activities under the direction of or in association with the Nazi government of Germany during World War II (paragraph (19) of section 241(a)). Paragraph 19, pertaining to Nazi war criminals, was added to the Immigration and Nationality Act in 1978. The Social Security Act was not amended to reflect this change at that time.

Explanation of Provision

The provision suspends benefits for an individual against whom a final order of deportation has been ordered on the basis of being a Nazi war criminal.

Effective Date

The provision is effective upon enactment.

Budget Effect

Negligible.

9. CLARIFY TERMS OF APPOINTMENT AND SUCCESSION FOR PUBLIC MEMBERS OF THE BOARD OF TRUSTEES

Present Law

Under current law, the Board of Trustees of the OASDI trust funds is composed of the Secretary of Treasury, the Secretary of Labor, the Secretary of Health & Human Services, and two members of the public (both of whom may not be from the same political party), nominated by the President for a term of four years and subject to confirmation by the Senate.

Explanation of Provision

The provision clarifies that a public member appointed to fill a vacancy occurring before the end of a term shall be appointed only for the remainder of such term, and specifies that a public member may serve after the expiration of his term until his successor has taken office.

Effective Date

This provision would be effective upon enactment.

Budget Effect

None.

10. MODIFICATION OF VOLUNTARY COVERAGE BETWEEN THE
STATE OF IOWA AND THE SECRETARY OF
HEALTH AND HUMAN SERVICES

Present Law

Under current law, a State may enter into an agreement with the Secretary of Health & Human Services to voluntarily cover State and local employees under social security. The coverage may extend to those groups of employees designated by the State.

In 1986, the Iowa State Supreme Court held that certain paid police and fire fighter departments in a number of Iowa communities were not covered under social security, although social security contributions had in fact been deposited with the Treasury. According to the Iowa Public Employees Retirement System, as many as 18 communities are continuing to make contributions to social security which are invalid and which build no protection for the employee.

Explanation of Provision

The provision allows the State of Iowa to modify retroactively its voluntary agreement with the Secretary of Health & Human Services to validate coverage for certain police and firefighters positions. The agreement must be modified prior to January 2, 1989.

Effective Date

This provision is effective upon enactment.

Budget Effect

Negligible.

11. RESTORATION OF WINDFALL BENEFITS

Present Law

The "windfall" social security benefit formula affecting persons with pensions from employment not covered by social security was enacted in the Social Security Amendments of 1983 (P.L. 98-21) in order to eliminate so-called "double-dipping" from the social security system.

The normal social security benefit formula is weighted so as to give proportionately higher benefits to low-earning workers. This is done by calculating the benefit according to a three-tiered benefit formula: 90 percent of the first \$310 of average indexed monthly earnings, 32 percent of earnings between \$310 and \$1866, and 15 percent of earnings above \$1866. Because this monthly earnings figure is arrived at by averaging the worker's lifetime covered earnings over a 35-year period, a worker with only 10 or 15 years of covered employment (even highly-paid employment) is treated under the benefit formula like a low-earning worker when those years are averaged over 35 years. Thus, relatively high-paid government workers received the benefit of the weighted formula, even though their pensions from non-covered employment were designed to pay the equivalent of social security plus a private pension.

In order to eliminate this windfall, Congress provided a special formula for persons with pensions from non-covered employment. This formula changes the first bracket of the three-bracket formula: instead of 90 percent of the first \$310 of average monthly earnings, it gives 40 percent of that amount, plus 32 percent of \$310 through \$1866, plus 15 percent of earnings above \$1866. (These dollar figures are for 1987 and increase each year according to the increase in wages). In addition, there is a limit on the reduction in any worker's social security benefits of one-half the amount of the non-covered pension. In addition, workers with 30 years or more of social security covered work are exempt from the windfall, and those with 29 to 26 years are subject to a phase-in of the 40 percent factor (from 80 percent for 29 years down to 50 percent for 26 years).

Explanation of Provision

The provision exempts from the windfall formula those Federal workers who join the newly-effective Federal Employee Retirement System and remain under the new system for 5 years or more.

Effective Date

The provision is effective upon enactment.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
1	1	1	3

12. CONTINUATION OF DISABILITY BENEFITS DURING APPEAL

Present Law

Under a provision that expires on December 31, 1987, a disability beneficiary who has been determined no longer disabled at the initial stage of administrative review may elect to continue to receive disability benefits throughout the administrative appeals process. Extended benefits provided with respect to determinations made on or before December 31, 1987 are last payable for June 1988 (i.e. the July 1988 benefit check). These benefits are subject to recovery as an overpayment in the event that the initial termination decision is upheld by an administrative law judge. The provision authorizing benefits pending appeal was first enacted as part of P.L. 97-455, and has been extended twice since then (most recently as part of the Social Security Disability Benefits Reform Act of 1984).

Explanation of Provision

The provision extends for one year the provision for continued payment of disability benefits during appeal. The last month of payments would be for June 1989 (i.e. the July 1989 check).

Effective Date

The provision would be effective on January 1, 1988.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
20	50	5	75

13. LENGTHEN THE EXTENDED PERIOD OF ELIGIBILITY
FOR DISABILITY BENEFITS

Present Law

Under current law, a social security disability beneficiary who returns to the workforce may become automatically reentitled to benefits within a 15-month extended period of eligibility, if the work effort fails and the person continues to suffer from a disabling impairment. The extended period of eligibility begins in the first month following the 9-month Trial Work Period, and allows an individual to have benefits reinstated without filing a new application for any month in which the person does not engage in substantial gainful activity (receipt of earnings of \$300 a month). The extended period of eligibility is intended to encourage disability beneficiaries to attempt to return to work without the fear that eligibility will be terminated and benefits will only be reinstated after a new application for benefits.

Explanation of Provision

The provision lengthens the extended period of eligibility from 15 to 60 months.

Effective Date

This provision would be effective January 1, 1988.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
1	5	6	12

14. INTERIM BENEFITS IN CASES OF DELAYED FINAL DECISIONS

Present Law

Presently, there is an administrative appeals system for disability claimants and beneficiaries under review composed of four levels: 1) an initial decision by a State agency; 2) State agency reconsideration; 3) a hearing before an Administrative Law Judge (ALJ); and 4) Appeals Council review. If an individual receives a favorable decision from an ALJ, the Appeals Council may on its own motion review the ALJ determination, and act to affirm, revise, reverse, or remand the ALJ decision.

Explanation of Provision

The provision requires that in any case in which an ALJ has determined that an individual is eligible for disability benefits and the Secretary has not acted within 90 days to issue a final decision, interim benefits will be provided to the individual pending the issuance of a final decision. These benefits will commence with the month preceding the month in which the 90-day period expires and will not be considered overpayments if eligibility is finally denied, unless the benefits were fraudulently obtained. Claimants whose own action resulted in delays without good cause would not be permitted to toll more than 20 such days toward the 90-day limit.

Effective Date

The provision would apply with respect to ALJ determinations occurring 180 days after the date of enactment.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
1	1	1	3

RECOMMENDATIONS OF THE SUBCOMMITTEE ON OVERSIGHT

1. SINGLE-EMPLOYER DEFINED BENEFIT PENSION PLAN REFORM

a. Minimum funding standards

Present Law

Under present law, certain defined benefit pension plans are required to meet a minimum funding standard for each plan year. The minimum funding standard requires that an employer contribute an annual amount sufficient to fund a portion of participants' projected benefits determined in accordance with one of several prescribed funding methods, using actuarial assumptions that are reasonable in the aggregate.

The annual amount required to be contributed under the minimum funding rules generally consists of two components: normal cost (i.e., the cost of future benefits allocated to the current year), and a portion of the plan's unfunded accrued liabilities (i.e., all charges other than normal cost, such as past service liabilities and experience losses). The total annual contribution must be paid to the plan no later than 8-1/2 months after the end of the plan year.

Under certain circumstances, an employer may obtain from the Internal Revenue Service a waiver of all or a portion of the contributions required under the minimum funding standard for a plan year. Waived contributions are required to be amortized over 15 years.

Explanation of Provision

The present-law minimum funding rules have proved inadequate in many situations to protect the benefits of plan participants and reduce the financial risk to the Pension Benefit Guaranty Corporation (PBGC). Current minimum funding rules do not adequately assure that plans will have enough assets to pay participants' benefits when due. In addition, under present law, a plan may satisfy the minimum funding rules yet lack sufficient assets to pay accrued benefits when the plan terminates.

In order to reduce the financial risk to plan participants and the PBGC, the Subcommittee recommendation requires certain plans to be funded more rapidly, depending on the funded status of the plan.

Under the Subcommittee recommendation, the minimum amount required to be contributed to a defined benefit plan for a plan year would be the plan's normal cost for the year plus the greatest of the following 4 amounts:

(1) the amount determined under the present-law standards for liabilities other than normal cost;

(2) an amount based on the funded status of the plan as a percentage of termination liability (the "termination liability rule");

(3) the amount determined under a rule requiring shorter funding for any decreases in the funded status of plans with assets less than termination liability (the "anti-deterioration rule"); or

(4) the sum of (i) the amount necessary to fund over 3 years the plan's unfunded expected liabilities, and (ii) nonannuity payments (e.g., lump sums) made to plan participants or beneficiaries during the year (the "anti-insolvency rule"). Expected liabilities are liabilities for benefits that are in pay status and for benefits expected to commence within 5 years.

Under the termination liability rule, unfunded termination liabilities would generally be funded over: (1) 3 years, in the case of a plan with assets less than 50 percent of termination liability, (2) 5 years, in the case of a plan with assets between 50 and 70 percent of termination liability, and (3) 15 years, in the case of a plan with assets greater than 70 percent of termination liability. Under a transition rule for existing unfunded termination liabilities, the termination liability rule would be phased in over 6 years with respect to such liabilities.

Experience gains and losses due to unreasonable interest assumptions would be required to be amortized over 3 years rather than over 15 years as under present law.

Under a transition rule for certain steel companies, the minimum required contribution for a plan year would be capped so that the plan's funded ratio would not be required to increase by more than a certain percentage.

In addition, in order to better ensure that required plan contributions are actually made, estimated contributions to plans would be required on a quarterly basis; the full contribution would be required to be made within 2-1/2 months after the end of the plan year; the liability for contributions would be extended to an employer's controlled group; and the availability of funding waivers would be restricted. Funding waivers would have to be requested sooner, a waiver would be available only if the entire controlled group is experiencing a substantial temporary business hardship, the frequency of permitted waivers would be reduced and the interest rate on waived contributions would be increased to a market rate. Also, the amortization period for waived contributions would depend on the funded status of the plan.

Effective Dates

The provisions would generally apply with respect to years beginning after December 31, 1987. For purposes of the transition rule for the termination liability rule, existing unfunded liabilities are unfunded termination liabilities on June 30, 1987, the date on which the Subcommittee recommendation was approved.

The requirement that plan contributions be made within 2-1/2 months after the plan year would be phased in over 2 years, for years beginning in 1988. The new rules relating to funding waivers would apply with respect to waivers granted after June 30, 1987.

b. Employer access to plan assets

Present Law

Under present law, pension plan assets may not be used for purposes other than for the exclusive benefit of employees and their beneficiaries. However, upon termination of the plan and after satisfaction of all fixed and contingent liabilities of the participants and beneficiaries (termination liability), the employer may recover the excess assets. The assets that revert to the employer generally are includible in gross income and subject to a nondeductible 10 percent excise tax.

Explanation of Provision

Although an employer technically is not permitted to recover excess assets except upon termination of a plan under present law, certain transactions that have the effect of a withdrawal of assets from an ongoing plan are permitted. Thus, present law permits employers to reduce the ratio of plan assets to termination liability, thereby reducing participants' benefit security and potentially increasing the risk of liability of the PBGC. Present law also permits an employer to recover excess assets from an overfunded defined benefit pension plan and use the assets for nonretirement purposes while maintaining underfunded defined benefit pension plans.

Under the Subcommittee recommendation, as under present law, an employer would be permitted to recover all assets in excess of the plan's termination liability upon plan termination. However, to the extent the employer (or controlled group) continues to cover the same employees under another defined benefit plan, the employer would be required to make contributions to the other plan with respect to such employees so that plan assets would equal the lesser of the amount of the reversion or 125 percent of termination liability.

In addition, if the employer (or controlled group) maintains defined benefit plans with assets less than the cushion amount, the employer would be required to make contributions to the plan over 3 years equal to the lesser of (a) the amount of the reversion or (b) the amount necessary to bring the asset level up to the cushion. Contributions under this rule are accelerated if the plan is terminated before the end of 3 years. The cushion amount is 125 percent of termination liability.

In order to more fully recapture the tax benefits received by the employer when an overfunded defined benefit plan is terminated, the excise tax on plan reversions would generally be increased to 20 percent. However, if assets are transferred in order to meet the requirements stated above, the excise tax would be 10 percent and the amounts transferred are not includible in gross income. This special rule is designed to encourage employers to meet the cushion requirements by direct transfers of plan assets.

Effective Date

The provisions generally would apply to plan terminations after June 30, 1987.

c. Termination of Underfunded plans

Present Law

A defined benefit pension plan may be terminated by the sponsoring employer only in a standard termination or in a distress termination. A plan may be terminated in a standard termination only if it has sufficient assets to pay all benefit commitments under the plan. Benefit commitments are greater than the benefits guaranteed by the PBGC, and include all guaranteed benefits and all benefits that would be guaranteed but for the dollar limit on the guarantee or the length of time the benefit has been in existence.

Benefit commitments are less than plan termination liability. Benefit commitments do not include benefits that vest solely due to plan termination or contingent benefits (such as early retirement benefits) for which the participant has not satisfied all conditions for entitlement prior to plan termination.

In order to terminate a plan in a distress termination, the plan administrator is required to demonstrate that the contributing sponsor and substantial members of the sponsor's controlled group meet certain criteria of financial distress.

In a distress termination, the liability of the employer to plan participants is limited to benefit commitments, and the liability to the PBGC is less than the amount of benefit commitments.

Explanation of Provision

Present law artificially limits the liability of the employer to plan participants and the PBGC. The Subcommittee recommendation would make employers fully liable for their pension promises.

Under the Subcommittee recommendation, an employer could terminate a plan in a standard termination only if the plan has assets sufficient to satisfy termination liability. In a distress termination, the employer would be fully liable to participants for the amount of termination liability, and to the PBGC for the full amount of guaranteed benefits.

In addition, in order to prevent an employer from transferring liability of one plan to the PBGC while obtaining a reversion from another plan, a distress termination would not be available if the employer (or controlled group member) maintains a defined benefit plan which has assets in excess of termination liability.

In order to prevent ongoing companies from transferring liabilities to the PBGC, the recommendation would provide that a Chapter 11 bankruptcy does not justify a distress termination. Appropriate provisions would ensure that the PBGC is adequately protected when an employer is involved in a Chapter 11 bankruptcy.

Following a distress termination, except to the extent permitted by the PBGC, an employer (or controlled group member) would be restricted from maintaining any retirement plan that provides similar benefits. Thus, an employer would be prevented from shifting pension liabilities to the PBGC while making additional retirement benefit promises.

Effective Date

The provisions would generally be effective with respect to terminations after June 30, 1987.

d. Miscellaneous

Present LawNotification of participants--

Under ERISA, plan participants and beneficiaries are entitled to certain information with respect to the plan.

Disqualified plans--

A recent court decision has raised the issue of whether the provisions of the Code are dispositive in determining whether a plan is qualified for Federal tax purposes.

Explanation of ProvisionNotification of participants--

The Subcommittee recommendation would require that employers make employees more aware of the plan's funding situation. Thus, the Subcommittee recommendation would require that employees be notified of the grant of a funding waiver and provided with additional information with respect to the funding of the plan.

Disqualified plans--

The Subcommittee recommendation would clarify that the provisions of the Code are to be applied in determining whether a plan is qualified.

Effective Date

The provision requiring notice of a funding waiver would be effective with respect to waivers granted after June 30, 1987. The provision requiring additional information with respect to the funding of the plan would apply to plan years beginning after December 31, 1987.

Budget Effect

(by fiscal years, in millions of dollars)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
37	60	54	151

2. PBGC SINGLE-EMPLOYER INSURANCE PROGRAM VARIABLE RATE PREMIUM PROPOSAL

Present Law

Under present law, if a defined benefit pension plan is terminated with assets insufficient to pay benefits guaranteed by the Pension Benefit Guaranty Corporation (PBGC), then the PBGC pays the monthly benefits required by the particular plan, up to the guaranteed levels. Subject to certain dollar limits, the PBGC guarantees nonforfeitable retirement benefits other than those that become nonforfeitable on account of the termination of the plan.¹ Guarantees are generally limited with respect to benefits in effect for fewer than 60 months at the time of plan termination.

Since its inception, the PBGC has charged a flat rate premium based on the number of plan participants. The Employee Retirement Income Security Act of 1974 (ERISA) initially authorized an annual per participant premium of \$1.00. The premium rate was raised to \$2.60 for plan years beginning in 1978. The Single Employer Pension Plan Amendments Act of 1985 (SEPPA) increased the rate to \$8.50 effective January 1, 1986. SEPPA also limited the situations in which an employer may terminate an underfunded pension plan and shift plan liabilities to the PBGC.

In addition to premiums, PBGC revenues include earnings on investments and collections from sponsors of terminated plans.

Despite the 1986 increase in the premium rate and the SEPPA restrictions on the circumstances under which employers may terminate underfunded pension plans and shift pension liabilities to the PBGC, the termination of underfunded pension plans increased the PBGC's deficit from \$1.3 billion as of September 30, 1985, to \$3.8 billion as of September 30, 1986. PBGC officials estimate that the expected increase in asset drain could cause the program not to have enough funds to pay annual costs in approximately 15 years.

Explanation of Provision

In order to improve the financial position of the pension insurance system and help ensure its continued viability, the Subcommittee on Oversight recommends an

¹ Present law requires that all benefits become nonforfeitable when a pension plan is terminated.

increase of the annual per-participant PBGC premium. The Subcommittee recommendation would increase the flat rate premium applicable with respect to all plans to \$15 and, in addition, would impose an additional premium with respect to plans which present a greater risk and exposure to the PBGC.

Under the Subcommittee recommendation, each plan that has a "funding charge insufficiency" (defined as the excess of 110 percent of vested benefits over plan assets) would pay an additional premium of \$5.50 per \$1,000 of the insufficiency per participant. The additional premium would not apply to plans with fewer than 100 participants. The total of the flat per-participant premium and the additional premium would not exceed \$50.

Effective Date

The provision would be effective with respect to years after December 31, 1987.

Budget Effect

(by fiscal years, in millions of dollars¹)

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-Yr. Total</u>
-436	-327	-285	-1,048

(1) Negative outlay.

3. TAX-EXEMPT ORGANIZATIONS' LOBBYING AND POLITICAL ACTIVITIES ACCOUNTABILITY ACT OF 1987

a. Disclosure Requirements

Present Law

Disclosure of Contribution Nondeductibility -- Under current law, contributions to tax-exempt organizations generally are allowed as charitable deductions for Federal income tax purposes only for contributions to organizations organized and operated for charitable, educational, religious, etc. purposes; contributions by individuals to fraternal organizations where such contributions are used exclusively for religious, charitable, scientific, etc. purposes; and contributions to certain veterans' organizations. There is no requirement that a tax-exempt organization which solicits contributions must state whether or not such donations are deductible as charitable contributions.

Disclosure of Exemption Applications and Annual Returns -- Present law provides that an organization's application for recognition of exemption and the annual information returns (except for donor lists) are disclosable to the public by the Internal Revenue Service. In addition, private foundations (but not public charities) are required to make their annual returns available for public inspection at their offices.

Explanation of Provisions

Disclosure of Contribution Nondeductibility -- Each fund-raising solicitation by or on behalf of an exempt organization (with annual gross receipts of more than \$100,000) which is not eligible to receive tax-deductible charitable contributions would have to contain an express statement that contributions to the organization are not deductible as charitable contributions for Federal income tax purposes.

Failure to provide such a statement (unless due to reasonable cause), as part of a solicitation occurring on a particular day, would subject the organization to a penalty of \$1,000 for that day. The maximum penalty that could be imposed for all such violations during a year would be \$10,000. If the failure is due to intentional disregard of the disclosure requirement, the penalty would be the greater of \$1,000 or 50% of the cost of the solicitation which contained the failure.

Disclosure of Exemption Applications and Annual Returns -- A public charity would be required to make available for public inspection at its offices a copy of its annual information return (for a 3-year period) filed with the Internal Revenue Service. Donor lists would not be disclosable. (Private foundations would remain subject to the public inspection requirements under present law.) All charitable organizations also would be required to make available for public inspection at their offices a copy of the application for recognition of exemption filed with the Internal Revenue Service. Penalties of \$10 a day would apply for failure to make available for public inspection the organization's annual return (up to a maximum of \$5,000) and its application for exemption.

Additional Information Required on Returns -- Additional information would be required on the annual returns of charitable organizations with respect to direct or indirect transactions and relationships with other tax-exempt organizations (except with other charitable organizations) or section 527 political organizations. This requirement would be intended to obtain information needed to prevent a diversion of funds from the organization's exempt purpose or misallocation of revenues or expenses and to develop similar necessary information.

Failure to include any of the required information on the annual return or to show the correct information (unless due to reasonable cause) would subject the organization to a penalty of \$10 a day, not to exceed the lesser of \$5000 or 5% of the gross receipts for the year. A subsequent failure to comply with an IRS demand for compliance with the filing requirements would subject the responsible persons to a penalty of \$10 a day, up to \$5,000.

Effective Dates

For fundraising solicitations, solicitations made after December 31, 1987.

For public inspection of annual returns, returns for years beginning after December 31, 1986.

For public inspection of applications of exemption, generally date of enactment.

For failure to provide information required on a return, returns for years beginning after December 31, 1986.

b. Political and Lobbying Activities

Present Law

An organization cannot qualify for exemption as a charitable organization, or to receive tax-deductible contributions, unless "no substantial part of [its] activities *** is carrying on propaganda, or otherwise attempting to influence legislation, and *** [the organization] does not participate in, or intervene in (including the publishing or distributing of statements) any political campaign on behalf of any candidate for public office."

In general, more than an insubstantial amount of lobbying or any political activity results in revocation of an organization's tax-exempt status. Private foundations are subject, in addition, to a series of excise taxes on prohibited expenditures.

Explanation of Provisions

Political Activities --

Clarification of Current Definition of Political Activity --

The current law definition of prohibited political activity would be clarified by expressly stating that political activity includes intervening in a political campaign in opposition to any candidate.

Imposition of Excise Tax for Political Activity --

A new excise tax, patterned after the two-tier excise tax on private foundation taxable expenditures, would be imposed on both a charitable organization and its responsible managers for engaging in political activity. A tax equal to 10% of the amount of the political expenditure would be imposed on the organization, and a tax (up to \$5,000) equal to 2 1/2 percent of the amount would be imposed on any organization manager who agreed to the making of the expenditure, unless agreement was not willful and was due to reasonable cause. If the violation is not corrected, additional excise taxes of 100% and 50% (up to \$10,000) of the expenditures would be imposed on the organization and the responsible managers.

Certain Political Expenditures Defined -- If a charitable organization is formed or used substantially for the purpose of promoting the candidacy (or potential candidacy) of an individual for public office, the payment of any of the following to or on behalf of that individual would be considered a political expenditure: speeches and other services; travel expenses; expenses of conducting polls, surveys or other studies, or preparing papers or other materials; advertising, publicity and fundraising expenses; and any other expense which has the primary effect of promoting public recognition of, or otherwise accruing to the benefit of, such individual.

Injunctive Relief for Flagrant Engagement in Political Activities -- In the case where charities flagrantly engage in political activities, injunctive relief would be authorized in certain limited circumstances. This action could only be brought if IRS has notified the organization to cease, and the Commissioner has personally determined that such organization has flagrantly engaged in political activities and that injunctive relief is appropriate to prevent future political expenditures. If the court so determines upon clear and convincing evidence, the court may enjoin the organization from making political expenditures and may grant other relief to ensure that the organization's assets are preserved for charitable purposes.

The IRS would be given the authority to make termination assessments in the case of flagrant political activities of a charitable organization, revoke the tax-exempt status, and immediately assess and collect any taxes due.

Lobbying Activities --

Excise Tax Where Exemption Revoked -- If an organization has had its exempt status revoked due to prohibited lobbying, an excise tax (5% of the amount of the expenditure) would be imposed on both the charitable organization and its responsible managers, unless such agreement is not willful and is due to reasonable cause. This provision does not apply to charitable organizations which have made the election under section 501(h) with respect to certain permitted lobbying expenditures.

Effective Date

Provisions would take effect on date of enactment.

Budget Effect

None.

RECOMMENDATIONS OF THE SUBCOMMITTEE ON HEALTH

1. HOSPITAL PROSPECTIVE PAYMENT RATES

Present Law

(a) Hospital Update Factor--Current law provides that for Fiscal Year 1988 hospitals payments per discharge will be increased at a rate equal to the market basket percentage increase minus two percent. The Secretary is required to recommend to the Congress an appropriate factor to be used to update payments per discharge in FY 88. The Secretary has recommended an update of .75% in FY 88.

(b) Increase Outlier Payments for Burn DRGs--PPS provides for an additional payment for cases that are extraordinarily long or costly in relation to other cases within a DRG.

Explanation of Provision

(a) Hospital Update Factor--The hospital update factor would be set as follows:

FY 88	FY 89	FY 90
1.0%	market basket minus 3.8%	market basket minus 1%

Present estimates are that the market basket will increase 5.4% in FY 89 and 5.7% in FY 90.

(b) Increase Outlier Payments for Burn DRGs--Outlier payments for the burn DRGs would be increased to 90% of cost for cost outliers or 90% of the appropriate per diem for day outliers. This level of reimbursement would continue until October 1, 1989. The Secretary would be directed to develop adjustments to PPS payments for the burn DRGs to assure that the costs of treating burn patients are being adequately reimbursed.

Effective Date

Effective for cost accounting periods beginning on or after October 1, 1987.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-year</u>
- 730	- 2,400	- 3,150	- 6,280

2. RURAL HOSPITALS

Present Law

(a) Update Factor for Rural Hospitals--There is no provision authorizing a differential update factor for rural hospitals.

(b) Swing Bed Program--The swing bed program is limited to rural hospitals with 50 beds or less, except that the Secretary may allow larger hospitals to participate in the program on a demonstration basis.

(c) Sole Community Providers--Certain isolated hospitals are eligible for designation as sole community providers. If so designated these hospitals receive 75% hospital-specific, 25% federal DRG payments and are eligible for an adjustment in the hospital-specific portion of their payment if the hospital's volume drops more than 5%.

(d) Rural Referral Hospitals--The Secretary may classify a hospital as a rural referral center if the hospital has more than 5,000 discharges and a case mix equal to or greater than urban non-teaching hospitals in its region.

(e) Adjusting for Different Area Wage Levels--The Secretary is authorized to adjust payments to hospitals based upon the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. The Secretary has implemented this provision by creating a wage index which is developed for each urban metropolitan statistical area (MSA) and for the rural, non-MSA part of each State.

(f) Rural Demonstration Projects--The Secretary is authorized under the Social Security Amendments of 1967 and 1972 to conduct demonstration projects.

Explanation of Provision.

(a) Update for Rural Hospitals--Rural hospitals would receive a 2% update in FY 88.

(b) Swing Bed Program--The proposal would expand the program to rural hospitals with up to 100 beds. For those hospitals over 50 beds the provision would require the transfer of swing bed patients when a nursing home bed becomes available in the geographic area and would cap swing bed days at 15% of available annual inpatient days.

The Secretary would be required to report to Congress on the swing bed program, including reporting on quality assurance and utilization review for long term care patients in hospital swing beds and making recommendations on encouraging swing beds in areas with high demand.

(c) Sole Community Providers--Hospitals which are either designated sole community providers or which meet the criteria for sole community provider designation would be eligible to receive the volume adjustment if they experienced a drop in volume greater than 5% due to circumstances beyond the hospital's control. The provision is extended to hospital cost accounting periods beginning before October 1, 1990.

The Secretary would be directed to issue instructions for implementing the volume adjustment in order to clarify the criteria for the adjustment. ProPAC would be directed to report to the Secretary on the appropriateness of the criteria.

(d) Rural Referral Centers--The Secretary would be directed to study and report to the Congress on the criteria used to classify rural referral centers and on the appropriateness of paying rural referral centers at a rate equal to a weighted average of urban and rural hospitals.

(e) Improving the Definition of hospital labor market areas--Upon application by a rural hospital which is located in a county which is adjacent to a metropolitan statistical area or areas, the Secretary would be required to adjust the labor portion of the hospital's PPS payment using the wage index weight of the adjacent urban area.

The hospital would be required to demonstrate to the satisfaction of the Secretary that the wages it must pay are comparable to those paid by hospitals in the adjacent urban area and that the average wages per standard unit of measure in the hospital are at least as high as the twenty-fifth percentile of the distribution of average wages for hospitals in the adjacent urban area. If the hospital was in a county adjacent to more than one MSA, the test may be applied against each adjacent MSA.

In implementing this policy the Secretary would be required to adjust payments in a budget neutral manner. This policy would be in effect for the three fiscal years beginning with FY 88.

The Secretary would be required to analyze the distribution of wage levels within and among existing areas used to adjust for differences in wage levels and report to the Congress by September 30, 1989. In so doing the Secretary would analyze the effect of variations in the occupational mix of hospital employees and differential fringe benefit levels on hospital costs.

Based upon his analysis the Secretary would be required to establish definitions of labor market areas which are based upon similarities in labor costs for similar skill mixes to replace the present practice of relying upon the definitions of metropolitan statistical areas developed by OMB.

(f) Rural Demonstration Projects--Would authorize the appropriation from the Medicare Part A Trust Fund of \$5 million in FY 88; \$5 million in FY 89, and \$5 million in FY 90 for grants to isolated and financially distressed rural sole community hospitals in order to demonstrate innovative ways to improve rural health care delivery.

Effective Date

The rural hospital update factor is effective for hospital cost accounting periods beginning during Fiscal Year 1988. The other provisions are effective upon enactment.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-year</u>
+ 40	+50	+50	+140

Authorized program costs; does not count towards reconciliation totals.

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-year</u>
5	5	5	15

3. PAYMENT FOR CAPITAL-RELATED COSTS

Present Law

Capital-related costs (including depreciation, interest, and rent, are excluded from the prospective payment system (PPS) until October 1, 1987. Until that time, capital costs continue to be reimbursed on a cost basis.

The Omnibus Reconciliation Act of 1986 reduced payment amounts for capital-related costs by 3.5 percent for portions of cost-reporting periods in fiscal year 1987, 7 percent for fiscal year 1988, and 10 percent for fiscal year 1989. The legislation exempts sole community hospitals from capital-related payment reductions.

If Congress does not enact legislation by October 1, 1987 to include capital-related costs under PPS, Medicare payments for capital costs will be prohibited after September 30, 1987, unless a State has a capital expenditure agreement with the Secretary (under section 1122 of the Social Security Act) and the State has recommended approval of the specific expenditure.

Explanation of Provision

Capital-related payment amounts would be reduced by 8.5 percent in FY 88, 10 percent in FY 89, and 10 percent in FY 90. Sole community providers would continue to be exempted from the reductions.

Capital-related costs would be excluded from the prospective payment system until September 30, 1991. The Secretary would be directed to include capital-related costs in the prospective payment system for hospital cost accounting periods beginning on or after October 1, 1991. In so doing the Secretary could initiate a transition to inclusion of all capital-related costs in the prospective payment system as of that date.

If the Secretary did not act to include capital-related costs or to commence a transition to including capital-related costs, no payment for capital-related costs would be allowed after October 1, 1991.

Mandatory capital expenditure review by States under section 1122 would not be required unless the Secretary failed to act to include capital in PPS by September 30, 1991.

The Prospective Payment Assessment Commission would be directed to study and report to the Committee on Ways and Means and the Committee on Finance on the suitability and feasibility of linking payment for capital-related costs to hospital occupancy. The report would be due by May 1, 1988.

Effective Date

October 1, 1987

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-year</u>
-70	0	-585	-655

4. HOSPITAL REPORTING

Present Law

At present hospitals file a Medicare cost report annually 90 days after the end of the hospital's accounting period. A 30-day grace period is allowed. There are no specific requirements regarding the accounting period.

Present law also directs the Secretary to promulgate by regulation a uniform system for the reporting of the aggregate costs and volume of services, the costs and volume of services for various functional accounts and subaccounts, rates, capital assets, and discharge and bill data. The Secretary has never implemented this provision.

Explanation of Provision

All hospitals would submit, 90 days after the close of each fiscal year, to the fiscal intermediary the annual cost report described below. The fiscal intermediary would employ a standardized software system to create a quarterly report at the end of each quarter based upon annual reports from hospitals with cost accounting periods ending during the prior four calendar quarters. The intermediaries would submit a summary and a hospital-specific report to the Committees on Ways and Means and on Finance, CBO, ProPAC, the Congressional Research Service and HCFA within 45 days after receipt. The report would include:

- Discharges, by patient type and by payer
- Patient days, by type and by payer
- Licensed beds and occupancy, by type
- Outpatient visits, by payer
- Inpatient net revenue, by payer, per case and per day
- Outpatient net revenue, by payer, per case and per day
- Expenses, total, by operating and capital, per case and per day
- Costs, as defined by Medicare principles
- Other net income
- Uncompensated care costs, total, and by bad debt and by charity care
- Capital Acquisitions
- Fixed Assets

All hospitals would be required to end their cost accounting periods at the end of a calendar quarter. The Secretary is authorized to make grants of up to \$100,000 from the Part A trust fund to ease the transition for any hospital which chooses a cost accounting period which is simultaneous with the federal fiscal year.

The Secretary would be directed to develop a new standard reporting system to replace the existing Medicare cost reporting system for hospitals, which would report: (a) hospital expenses and volume of services by specific categories and by cost centers; (b) hospital charges and patient revenue, by category of patient and payer, including, but not limited to, Medicare, Medicaid, other third-party payers, and self-payers, and by revenue-producing center; (c) bad debt and charity care; (d) contractual allowances; (e) non-operating revenues; (f) licensed beds, by category of service; (g) capital assets; (h) balance sheet.

The Secretary would develop the report such that electronic submission of the report by providers to the fiscal intermediaries and subsequent transmission to HCFA is facilitated. The report should minimize, to the extent feasible, the reporting requirements of hospitals and should be compatible with the needs of the Medicare prospective payment system.

The Secretary would be required to develop a preliminary report by June 30, 1988. Hospitals would be required to use the new uniform report for accounting periods beginning in FY1989.

Hospitals which receive more than \$10 million per year in Medicare revenue would be required to report to the fiscal intermediaries on an electronic basis for cost accounting periods beginning in FY1990.

Hospitals would be required to submit the new report for accounting years beginning in FY 89. Payments would be reduced in the following quarter by 5% for intermediaries and for hospitals which do not submit the data and/or report as specified.

Effective Date

Upon enactment

Budget Effect

Authorized program costs; does not count towards reconciliation totals

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-year</u>
+10	+10	+5	+25

5. PAYMENT THRESHOLD FOR PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES

Present Law

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) allowed skilled nursing facilities providing less than 1,500 days of care per year to Medicare patients in the preceding year the option of being paid a prospective rate. The rate is set at 105 percent of the regional mean for all skilled nursing facilities in the region.

The prospective per diem rates are separately calculated for urban and rural areas and include all non-ancillary costs, including capital and return on investment if Medicare pays skilled nursing facilities for a return on equity capital. These rates are also adjusted to reflect wage differences between urban and rural areas and between rural areas within each region. The prospective urban or rural regional per diem rate for a skilled nursing facility cannot exceed the per diem cost limit otherwise applicable to that facility adjusted for capital costs.

Prospective payment on this basis took effect for facilities that elected such payment for cost reporting periods beginning on or after October 1, 1986.

Explanation of Provision

The threshold for the optional prospective payment rate for skilled nursing facilities would be raised to up to 2,500 days of care per year to Medicare patients in the preceding year.

Effective Date

Prospective payment on this basis would take effect for facilities that elect such payment for cost reporting periods beginning on or after October 1, 1989.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
0	0	+60	+60

6. SKILLED NURSING FACILITY STANDARDS REFORM

Present Law

(a) Requirements Relating to Provision of Services in a Skilled Nursing Facility--Under current law, in order for a skilled nursing facility to participate in the Medicare program it must be approved for Medicare participation by the Federal government and have signed a participation agreement. To qualify for participation in the Medicare program, an institution must be a "skilled nursing facility" within the meaning of Section 1861(j) of the Social Security Act.

Section 1861(j) lists several requirements skilled nursing facilities (SNF) must meet, the most important of which is that the SNF "is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for rehabilitation of injured, disabled or sick persons." This section also requires that a SNF: (1) have physicians supervising the care of its patients, (2) maintain clinical records on all patients, (3) provide 24-hour nursing care, (4) have in effect a utilization review plan, (5) establish a system to prevent the commingling of patients' funds, (6) and meet certain health and safety requirements.

(b) Survey and Certification Process--In order to ensure compliance with these requirements the Secretary of the Department of Health and Human Services generally enters into an agreement with the State to annually survey the Medicare skilled nursing facilities in the State to determine compliance and certifies the same. The Federal government pays for the cost of the survey and certification process.

(c) Enforcement Process--Under current law where the Secretary determines that the SNF's deficiencies immediately jeopardize the health and safety of its patients, the Secretary provides for the termination of the facility's participation agreement. If the deficiencies do not immediately jeopardize the health and safety of the patients, the Secretary, in lieu of termination, may deny Medicare or Medicaid payment with respect to any individual admitted to such facility after a certain date.

Explanation of Provision

Requirements Relating to Provision of Services in a Skilled Nursing Facility--In order to participate in the Medicare program a skilled nursing facility would be required to meet the following new requirements: (1) provide services that will attain or maintain the highest possible physical, mental and psychosocial well-being of each resident, (2) conduct an assessment of each resident's physical, mental and psychosocial needs and develop a plan of care to meet those

needs, (3) employ only nurse aides who have completed an appropriate training or testing program (100 hours of initial training) before they were allowed to provide care for which they have been properly trained, (4) meet the social service needs of the residents, and (5) protect a variety of resident's rights including access and visitation rights, transfer and discharge rights and protect resident's funds.

Skilled nursing facilities would also have to maintain the current requirements: (1) provide 24 hour nursing care with a registered nurse for at least the day shift seven days a week with certain exceptions permitted (2) provide medical care to every resident under the supervision of a physician (3) meet certain health and life safety code requirements.

(b) Survey and Certification Process--The Secretary would be required to enter into an agreement with each State to subject each SNF participating in the Medicare program to a standard survey at least every 15 months, with a statewide average of 12 months, and an extended survey for facilities found to provide poor quality of care.

(c) Enforcement Process--If the state or Federal government found that a SNF no longer met the conditions of participation and further found that the facility's deficiencies immediately jeopardized the health or safety of its residents, the state would be required to take immediate action to remove the jeopardy and correct the deficiencies (including the appointment of temporary management) or terminate the facility's participation. If the facility's deficiencies do not immediately jeopardize the health or safety of its residents, the state may apply intermediate sanctions including: (1) denial of payment for new residents, (2) assessing monetary penalties, or (3) placing the facility under the appointment of temporary management.

Effective Date

(a) The new requirements would apply to services furnished on or after January 1, 1989; (b) the new survey and certification process requirements would be effective for services furnished on or after January 1, 1989; (c) and the enforcement provisions would be effective for surveys conducted on or after January 1, 1989.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
0	+30	+45	+75

7. MISCELLANEOUS PART A PROVISIONS

Present Law

(a) Update for PPS exempt-Providers--For FY 88 present law requires that payments per discharge for all hospitals are to be updated at a rate equal to the market basket increase minus two percent. The Secretary is required to recommend for FY 88 and determine for subsequent years an update factor for each fiscal year. The Secretary is authorized to propose or determine an update factor for PPS-exempt hospitals which is different than that for PPS hospitals.

(b) Clarification of State Waiver Test--State hospital reimbursement control systems which received a waiver of the Medicare principles of reimbursement prior to the enactment of the Social Security Amendments of 1983 under various statutory authorities may, at the request of the State, be judged for effectiveness in two different ways. The Secretary is directed to judge the effectiveness of the system on the basis of the State's rate of increase in total Medicare payments versus the national rate of increase in total Medicare payments, or, at the request of the State, on the basis of aggregate payments per admission or per discharge in the State and in the nation.

(c) Conditions of Participation Regarding Podiatrists--Podiatrists are considered to be physicians with respect to the functions which they are legally authorized to perform under the laws of the State in which they practice but only if such practice is consistent with the policy of the institution or agency in which the services are provided.

(d) Amendment to section 1814(b) State Waiver Authority--The Secretary may continue payment to hospitals in accordance with an alternative state hospital reimbursement system which is authorized by the State legislature and which was initially established as a demonstration under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, until the Secretary determines that (1) a third party payer reimburses a hospital in the State on a basis other than the alternative system or (2) the rate of increase in Part A cost per inpatient hospital admission for the previous three-year period exceeds the national rate of increase in such costs per admission.

(e) Continuation of Bad Debt Payments to PPS Hospitals--Under current regulations the Medicare program makes payments to hospitals to reimburse hospitals for Medicare bad debt, defined as the unrecovered costs associated with unpaid Medicare deductible and coinsurance. In order for unpaid deductible and coinsurance to be considered a bad

debt, the bad debt must be related to covered services furnished to a beneficiary and the hospital must meet certain collection criteria.

(f) Technical Part A Amendments--There are a number of drafting errors in current law provisions added by OBRA-86.

Explanation of Provision

(a) Update for PPS-exempt Providers--PPS-exempt hospitals would receive an update of 2.9% in FY 88 and an update factor equal to the increase in the market basket in FY 89 and FY 90.

(b)--Clarification of State Waiver Test--Would clarify that the entity which received a waiver for a state-wide hospital reimbursement control system, whether or not it is a State, may make a request regarding the basis on which the judgment of effectiveness is made with respect to the State system. The amendment applies to cost accounting periods beginning on or after October 1, 1983 as in present law. It is anticipated that Massachusetts will make a request under this authority.

(c) Conditions of Participation Regarding Podiatrists--Podiatrists would be defined as physicians with respect to the functions which they are legally authorized to perform under State laws.

(d) Amendment to section 1814(b) State Waiver Authority--In measuring the effectiveness of an alternative reimbursement system the Secretary would compare the rate of increase in costs per admission from October 1, 1983 to the end of the most recent period for which annual data is available for hospitals under the alternative system to the rate of increase in such costs for all hospitals in the United States during the same period.

(e) Continuation of Bad Debt Payments to PPS Hospitals--The Secretary would be required to continue payments for Medicare bad debt as under current policy.

(f) Technical Part A Amendments--A number of drafting errors in current law would be corrected.

Effective Date

Paragraph (a) effective for hospital cost accounting periods beginning on or after October 1, 1987. Paragraphs (b), (c), (d), and (e) effective upon the date of enactment

Budget Effect

None

8. PAY STANDARDS

Present Law

Requires (for Medicare claims not paid on a PIP basis) payments to be made by a Part A intermediary for at least 95% of all Medicare clean claims by the applicable number of calendar days after the day on which a clean claim is received. In FY 87, the applicable number of calendar days is 30, 26 for FY 88, 25 for FY 89, and 24 for FY 90 and for each of the subsequent years.

For clean claims not paid on a PIP basis, if payment is not made by the applicable number of days after the date on which a clean claim is received, interest is required to be paid beginning on the day after the date on which payment was due, and ending on the date payment is made.

For Part B, the requirements are the same except that for participating physicians, the applicable deadlines for payment on 95% of clean claims are 19 days in FY 88, 18 for FY 89, 17 for FY 90 and for subsequent years. Interest accrues for payments not paid within the specified time period.

There is no standard in current law regarding the average time over which all payments shall be made.

Explanation of Provision

The Secretary would be required to manage payments to providers under the program in order to achieve an average time period between receipt of a clean claim and payment by the fiscal intermediary or the carrier of 21 days in FY 88, 22 days in FY 89, and 23 days in FY 90. The Secretary could not adopt any other policy which has the effect of further delays in payment.

In so doing the Secretary would be required to delay payments by each intermediary or carrier by an equal amount for each Part. The Secretary would be authorized, however, to adjust the time delay upward, by only the amount necessary, for intermediaries and carriers which pay more quickly on average in order to compensate for those intermediaries and carriers which would otherwise exceed the ceilings required by section 1816(c) and section 1842(c).

The General Accounting Office would be required to review and report to the Committees on Ways and Means and Finance by December 31, 1987 on the implementation by the Secretary of this policy.

Effective Date

October 1, 1987

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-year</u>
-480	-220	-280	-980

Authorized Program Costs; does not count toward reconciliation totals.

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-year</u>
15	5	0	20

9. RETURN ON EQUITY FOR HOSPITAL OUT-PATIENT DEPARTMENTS
AND SKILLED NURSING FACILITIES

Present Law

(a) Out-patient Departments--The Secretary is authorized to pay a return on equity capital to proprietary providers for services reimbursed on a reasonable cost basis. If the Secretary elects to provide for a return, the payment must be equal to the average rates of increase on obligations issued for purchase by the Part A trust fund.

(b) Skilled Nursing Facilities--Requires payment of reasonable return on equity for proprietary skilled nursing facilities (SNFs). A rate of return equal to 100% of the average annual interest paid by the Part A trust fund is paid to proprietary providers on their amount of net equity capital.

Explanation of Provision

(a) Outpatient Departments--The provision would eliminate the Secretary's authority to pay return on equity to hospital outpatient departments.

(b) Skilled Nursing Facilities--The provision would eliminate the requirement that proprietary SNFs must be paid return on equity.

Effective Date

October 1, 1987

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3-year</u>
-55	-60	-65	-180

10. REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS AND CAPITATION DEMONSTRATION PROJECTS

Present Law

(a) Provides for civil monetary penalties and/or intermediate sanctions for Health Maintenance Organizations (HMOs) and competitive medical plans (cmps)--Current law provides for civil monetary penalties for HMOs/cmps which deny medically indicated treatment. The intermediate sanctions of freezing enrollment and terminating payment for new enrollees can be imposed for violation of the requirement that no more than 50% of an HMO or cmp's membership be beneficiaries of Medicare and Medicaid.

(b) Criminal Penalties--Present law makes it a felony and permits penalties of a fine not exceeding \$25,000 or up to 5 years in jail for officers of a hospital, skilled nursing facility, or home health agency who falsify conditions of operation of the facility in order to qualify or continue to qualify for payment from Medicare. Present law does not include officers of other entities which participate in Medicare among those who are subject to criminal sanctions.

(c) Limiting Medicare Physician and Hospital Capitation Demonstrations--Section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967 authorize the Secretary to waive provisions of Title XVIII in order to initiate demonstrations.

Explanation of Provision

(a) Provide for Civil Monetary Penalties and/or Intermediate Sanctions for Health Maintenance Organizations (HMOs) and competitive medical plans (cmps)--The provision would authorize the Secretary to impose civil monetary penalties, impose enrollment or admission restrictions, and/or withhold payments due to HMOs and competitive medical plans which: (a) charges Medicare beneficiaries more than the amount permitted by a contract with the Secretary; (b) acts to expel or to refuse to re-enroll an individual due to health status; (c) engages in any practice which can reasonably be expected to deny or discourage enrollment or re-enrollment to individuals based upon their health status; (d) enrolls an individual without that person's knowledge or consent; and/or, (e) misrepresents or falsifies information provided to the Secretary or a beneficiary regarding the plan's cost, benefits, or services.

(b) Criminal Penalties--The amendment would include officers of Health Maintenance Organizations, competitive medical plans, comprehensive outpatient rehabilitation facilities, ambulatory surgical centers, hospices, and rural health clinics in the list of those persons who will be held criminally liable for willful misrepresentations in an attempt to qualify for Medicare payments.

(c) The Secretary would be prohibited from conducting any capitation demonstration projects involving more than \$15 million in Medicare funds unless Congress specifically authorized each such demonstration in statute.

In conducting any capitation demonstration project the Secretary would be prohibited from authorizing a capitated payment of more than 95% of the adjusted average per capita cost established for HMOs and CMPs in the region.

Effective Date

Upon enactment.

Budget Effect

None.

11. MISCELLANEOUS PART A and PART B PROVISIONS

Present Law

(a) Impact Analysis of Medicare Part A Regulations on Rural Health Care--There is no provision regarding analysis of the impact of regulations on rural health care.

(b) Extend Period and Stagger Expiration of PRO Contracts--Peer review organization (PRO) contracts are required to be for two years.

(c) Limit Liability for PRO Disallowed Services--No Medicare payment may be made for a service that is determined to have been unnecessary or of substandard quality. In addition, a physician may not bill a beneficiary for an unnecessary service and may be required to make a refund. In contrast, a physician may bill a beneficiary for services found to be substandard even though Medicare payment will be denied. Furthermore, a hospital can charge a beneficiary for the inpatient hospital deductible even though Medicare payment for hospitalization was denied for reasons of medical necessity or quality.

(d) Require Publication of Intermediary/Carrier Contract Methodology--The Secretary is required to publish in the Federal Register the standards and criteria used to evaluate Medicare fiscal intermediaries and carriers. In paying fiscal intermediaries and carriers for their services, the Secretary is required to take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization. There is no requirement that the Secretary publish the methodology by which he determines this amount.

(e) Extend and Clarify Prohibition on Cost Savings Policies Before the Beginning of the Fiscal Year--The Secretary is prohibited from issuing any regulation, instruction, or other policy in final form prior to September 1, 1987 which is estimated by the Secretary to result in a net reduction in expenditures during FY 1988 of more than \$50,000,000 for hospital or physician services provided under Medicare.

(f) Revise ProPAC/PhysPRC Appointment Process--In appointing the members of the Prospective Payment Assessment Commission and the Physician Payment Review Commission, the Director of the Office of Technology Assessment is required to consult with a variety of national organizations in seeking nominations.

(g) Technical Part A and B Amendments--There are a number of drafting errors in current law provisions added by OBRA-86.

Explanation of Provision

(a) Impact Analysis of Medicare Part A Regulations on Rural Health Care--The Secretary is required in promulgating Notices of Proposed Rule Making and final regulations to include an analysis of the impact of the proposed or final rule on health care in rural hospitals and on small rural hospitals.

(b) Extend Period and Stagger Expiration of PRO Contracts--The Secretary would be given more flexibility with respect to the duration of PRO contracts and could stagger contract expiration dates. Specifically, the Secretary would be authorized to: (i) extend existing PRO contracts for up to six months if necessary to complete contract renewal negotiations, (ii) provide up to two one-year extensions for existing PRO contracts, (iii) negotiate renewal contracts for periods of three years with PROs found to be performing satisfactorily.

(c) Limit Liability for PRO Disallowed Services--Physicians would be prohibited from billing for a service determined to be of substandard quality and would be required to make a refund if payment has been received from the beneficiary. Hospitals would be prohibited from billing a beneficiary for the inpatient hospital deductible (and would be required to make a refund, if necessary) if Medicare payment has been denied because the hospital admission was unnecessary or care provided by the hospital was substandard.

(d) Require Publication of Intermediary/Carrier Contract Methodology--The Secretary is required to publish in the Federal Register, for public comment, the procedures, criteria, and data used to establish intermediary and carrier budgets.

(e) Extend and Clarify Prohibition on Cost Savings Policies Before the Beginning of the Fiscal Year--The Secretary would be prohibited from issuing any regulation, instruction, or other policy in final form prior to October 15, 1988 which is estimated by the Secretary to result in a net reduction in expenditures during FY 1989 of more than \$50,000,000 for benefits covered under Medicare.

(f) Revise ProPAC/PhysPRC Appointment Process--The requirement that the Director of the Office of Technology Assessment seek nominations from various organizations is repealed. In the case of ProPAC, the Director shall appoint individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields. In the case of PhysPRC, the Director shall appoint individuals with national recognition for their expertise in health economics, physician reimbursement, medical practice, and other related fields.

(g) Technical Part A and B Amendments--A number of drafting errors in current law would be corrected.

Effective Date

Upon enactment.

Budget Effect

None

12. PHYSICIAN PAYMENT UPDATE

Present Law

The Medicare approved charge for physicians' services is the lowest of a physician's billed charge, the charge customarily made by the physician, or the prevailing charge limit (derived from charges made by physicians in an area).

Increases in prevailing charges are limited by the Medicare Economic Index ("MEI") which reflects yearly increases in overhead costs. The MEI for 1988 is projected to be 3.2 percent.

Payment may be made on an "assigned" or "unassigned" basis. If assignment is accepted, the physician agrees to accept the Medicare approved charge as payment in full. If assignment is not accepted, the physician may charge extra.

Because of concern about extra charges on unassigned claims, the Deficit Reduction Act of 1984 established the participating physician program. Participating physicians agree to accept assignment on all Medicare claims. To provide incentives for participation, the prevailing charges limit for participating physicians is set 4 per cent higher than for nonparticipating physicians.

Explanation of Provision

For calendar year 1988, participating physicians would receive a prevailing charge increase of 2 percent. Nonparticipating physicians would receive a 1 percent increase. To implement this provision, the Secretary would be required to set prevailing charges for nonparticipating physicians at 95 percent of the prevailing charges for participating physicians.

Effective Date

January 1, 1988.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
-120	-190	-230	-540

13. OVERPRICED PROCEDURES

Present Law

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) established guidelines for setting prevailing charges on the basis of "inherent reasonableness" and reduced prevailing charges for cataract surgery and cataract surgery anesthesia effective January 1, 1987.

OBRA-86 also established special limits on actual charges for cataract surgery and other procedures subject to payment reductions under inherent reasonableness. These limits are necessary to minimize potential increases in out-of-pocket costs for beneficiaries.

Explanation of Provision

The Secretary would be required to reduce prevailing charges for selected procedures. The list is based on recommendations of the Physician Payment Review Commission. The procedures are coronary artery bypass surgery, total hip replacement, cataract surgery, transurethral prostatectomy, suprapubic prostatectomy, diagnostic dilatation and curettage, and carpal tunnel repair.

Effective January 1, 1988, prevailing charges for each of these procedures would be reduced 15 percent below levels in effect during 1987. A floor would be set at 75 per cent of the weighted national average prevailing charge for 1987 based on the best available data. In no instance, would prevailing charges be reduced below this level.

Limits on actual charges would apply to prevent increases in out-of-pocket costs for beneficiaries. During the first year, charge limits would be set half-way between the physician's billed charge for the procedure during the preceding year and 125 percent of the prevailing charge level. During the second year, the charge limit would be set at 125 percent of the prevailing charge. Starting in the third year, the charge limit would be set at 115 percent.

Effective Date

January 1, 1988.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
-85	-165	-175	-425

14. LIMITS ON PAYMENT FOR ULTRASOUND AND LENS IMPLANTS
FOR CATARACT SURGERY

Present Law

There are no special limits on payment for A-scan ultrasound procedures performed in conjunction with cataract surgery. The percentage of cataract operations for which there is a separate charge for A-scans has doubled since 1984.

In addition, there is no limit on payment for prosthetic lenses implanted in physicians' offices or in ambulatory surgery centers during cataract surgery. Payment for lenses provided in these settings may be substantially in excess of cost. Lenses implanted in hospital outpatient departments are reimbursed on a cost basis.

Explanation of Provision

The prevailing charge for A-scan ultrasound procedures performed in conjunction with cataract surgery would be limited to 5 percent of the prevailing charge for cataract surgery with lens implantation.

Payment for intraocular lenses implanted during cataract surgery in physicians' offices and ambulatory surgery centers would be limited to acquisition cost net of any discount plus a handling fee not to exceed 10 percent. Limits on actual charges specified under item 13 would apply to prevent cost-shifting to beneficiaries.

Effective Date

January 1, 1988.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
-28	-45	-50	-123

15. PAYMENT FOR RADIOLOGY, ANESTHESIOLOGY,
AND PATHOLOGY SERVICES

Present Law

Physicians are paid on a basis of an itemized claim for individual services. The amount of payment allowed is based on the lowest of the actual, customary charge, or prevailing charge.

Explanation of Provision

The Secretary would be authorized to implement a prospective payment system under Medicare Part B for inpatient radiology, anesthesiology, and pathology (RAP) services effective January 1, 1989. Payment would be based on diagnosis related groups (DRGs). The DRG payment would cover all RAP services, as well as services provided by Certified Registered Nurse Anesthetists.

In no instance would payments be made to hospitals. Physicians will be paid directly, generally on a fee-for-service basis in proportion to submitted charges, subject to an overall expenditure cap set by the DRGs. Physicians would, however, have the opportunity to choose other options for receiving payment. Physicians could receive an undivided per case payment or could request a special division of the per case payment.

Physicians at rural hospitals with fewer than 150 beds would have the option of being exempted from DRG payment.

Payments would be based on national rates with an adjustment for cost of practice and cost of living. The Secretary would be authorized to provide for an adjustment for teaching hospitals. The Secretary would be required to provide for an annual update in payment rates.

The Secretary would be required to limit actual charges on unassigned claims as needed to ensure that DRG payment will not result in an increase in out-of-pocket costs for Medicare beneficiaries. Medicare beneficiaries would continue to pay 20 percent coinsurance.

Effective Date

January 1, 1989.

Budget Effect

None.

16. PROHIBIT BILLING FOR PURCHASED SERVICES

Present Law

Payment for a clinical diagnostic lab test may be made to a physician only if the physician (or another physician in the same practice) personally performed, or supervised the performance, of the test. The purpose is to prevent excessive payments resulting from mark-ups on charges for tests purchased by physicians from independent labs. Clinical diagnostic lab tests include blood tests and other similar tests. Other diagnostic tests, such as ambulatory cardiac monitoring, are not included. These tests are not covered by the prohibition on billing for purchased services.

Explanation of Provision

No Medicare payment would be made to a physician for any diagnostic test, as defined under Section 1861(s)(3), unless the physician (or another physician in the same practice) performed, or supervised the performance of the test. Physicians would also be prohibited from billing Medicare beneficiaries in these circumstances. Knowing and willful violations on a repeated basis would be subject to civil monetary penalties of up to \$2,000 or exclusion from Medicare.

The Secretary would be required to review and reduce, as appropriate, Medicare prevailing charge levels for diagnostic tests commonly purchased from another vendor and billed by physicians. In establishing new prevailing charge levels, the Secretary would be required to take into account the purchase price for physicians. The Secretary would be authorized to require physicians or suppliers to provide information on purchase price. The Secretary would be required to establish new prevailing charge levels by no later than January 1, 1989. The review responsibility could be delegated to the Medicare carriers.

Effective Date

January 1, 1988.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
-5	-10	-10	-25

17. COMPLETION OF FORMS FOR UNASSIGNED CLAIMS

Present Law

If a physician accepts assignment, the physician must submit a claim form to Medicare requesting payment. If assignment is not accepted, the physician bills the beneficiary who in turn is responsible for submitting a claim to Medicare for reimbursement.

Because of the difficulty involved in obtaining a claim form and filling it out properly, in a small percentage of cases, beneficiaries fail to submit a claim and do not receive benefits to which they are entitled. Moreover, beneficiary submitted claims are more costly to process and contain more errors, which result in reconsiderations and appeals.

Explanation of Provision

Physicians would be required to complete the standard Medicare claims form in every instance in which services are provided to a Medicare beneficiary. Physicians would be required to submit the claim form on behalf of the beneficiary to the Medicare carrier. Knowing and willful failure on a repeated basis to comply with this requirement would be subject to civil monetary penalties and/or exclusion from the program.

Effective Date

January 1, 1989.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
0	60	100	160

18. SUBMISSION OF CLAIMS TO SUPPLEMENTAL INSURANCE CARRIERS

Present Law

Physicians and suppliers who accept assignment must submit a claim to Medicare and bill the beneficiary or the beneficiary's supplemental Medicare ("Medigap") insurer to receive payment for the standard 20 percent coinsurance. If assignment is not accepted, the physician or supplier simply sends a bill to the beneficiary. Although there are federal standards for certification of Medigap policies, there are no standards for payment coordination. Some Medigap insurers currently exchange claims information with Medicare.

Explanation of Provision

A simplified billing arrangement would be offered to participating physicians and suppliers to reduce duplicate billing. A beneficiary could assign his right to payment under a Medigap policy to a physician or supplier by including the name and address of the Medigap insurer and the Medigap policy number on the Medicare claim form. (If the beneficiary has more than one Medigap policy the beneficiary would decide which policy would be reported.)

When a Medicare carrier receives a claim from a participating physician or supplier with an assignment of rights to payment under a Medigap policy, the carrier would be required to send a notice of payment to the Medigap insurer. The notice would indicate the fact that the beneficiary has assigned his right to payment under the Medigap policy and would include information to enable the Medigap insurer to decide whether payment is due and the amount. The Secretary would be authorized to enter into agreements with Medigap insurers to provide notices of payment by electronic transmission and to charge for such service.

Current standards for Medigap insurance policies would be amended to require that: (i) Medigap insurers agree to accept the notice of payment in lieu of a standard claim, (ii) pay participating physicians and suppliers directly and provide a notice concerning claim disposition to the physician or supplier and the beneficiary, (iii) provide each Medigap subscriber with a card listing the name and address of the insurer and the beneficiary's policy number, as well as providing a mailing address to Medicare.

Effective Date

January 1, 1989.

Budget Effect

Authorized program; does not count toward reconciliation totals.

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
0	35	35	70

19. COVERAGE OF THERAPEUTIC FOOTWEAR FOR DIABETICS

Present Law

Under current law Medicare does not provide coverage or reimbursement for therapeutic footwear required for the treatment of severe diabetic foot disease.

Explanation of Provision

Medicare would provide coverage of therapeutic footwear for a Medicare beneficiary with severe diabetic foot disease when the physician managing the beneficiary's care certified the medical need for the therapeutic footwear. Following certification, a podiatrist or other qualified physician would be required to prescribe the particular type of footwear necessary, and the footwear would be fitted and furnished by a podiatrist or other qualified individual. To avoid conflicts of interest, the physician who certified the need for the footwear would not be allowed to furnish the footwear, unless the physician would be the only one qualified individual in the area.

Medicare would allow payment for only one pair of footwear a year. Payment for therapeutic footwear would be limited to 80 percent of the reasonable charge, up to a limit of \$300 for custom molded shoes, \$100 for extra-depth shoes, and \$50 for shoe inserts. These amounts include payment for any expenses for the fitting of such footwear. The limits may be lowered by the Secretary or a carrier if the Secretary finds that shoes and inserts of an appropriate quality are readily available below such limits. The limits would be indexed by the same percentage increase allowed for durable medical equipment for future years.

Effective Date

The provision would be effective for therapeutic footwear furnished on or after January 1, 1988.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
-20	-35	-40	-95

20. MISCELLANEOUS PART B PROVISIONS

Present Law

(a) Uniform List of Procedures--Medicare carriers have responsibility for defining procedures for payment purposes.

(b) Capacity to Set Geographic Payment Limits--There are no regional or national limits on payment under current law.

(c) Expand Relative Value Study--The Secretary is required to conduct a study to develop a relative value scale (RVS) for physicians' services. The report is due July 1, 1989.

(d) Civil Penalties for Unassigned Lab Services--Assignment is required on all claims for clinical diagnostic laboratory services. No payment may be made if assignment is not accepted.

(e) Revise MAAC Limits--The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) established the maximum allowable actual charge ("MAAC") limits to prevent increases in extra charges for beneficiaries on unassigned claims. For 1987, MAACs are based on actual charges during the April-June 1984 base period. If a physician's base period actual charge exceeds 115 per cent of the 1987 prevailing charge, the MAAC is 101 percent of the base period charge. Otherwise, the MAAC equals the base period charge increased by one quarter of the difference between the 1987 prevailing charge and base period charge. For physicians without a base period charge, the MAAC is based on the 50th percentile of customary charges of nonparticipating physicians during July 1986-June 1987. Similar rules apply for 1988, 1989, and 1990. MAACs are provided to physicians at the beginning of each year. If a physician knowingly and willfully charges on average more than the applicable MAAC, the physician would be liable for civil monetary penalties or exclusion from Medicare.

(f) Prompt Submission of Data by HCFA--The Secretary has developed a national Part B data system known as the Part B Medicare Annual Data System ("B-MADS").

(g) Physician Payment Studies--The Secretary routinely conducts studies on a variety of issues related to Medicare.

(h) Apply Prompt-Pay Interest Requirement to Rehabilitation Facilities--In general, hospitals and physicians and suppliers of medical equipment receive interest payments from Medicare if the time period for payment of clean claims exceeds a specified period. Interest payments are not required for Part B providers paid by intermediaries.

(i) Technical Part B Amendments--There are a number of drafting errors in current law provisions added by OBRA-86.

Explanation of Provision

(a) Uniform List of Procedures--The Secretary would be required to develop uniform definitions of physicians' services for payment purposes. Ancillary procedures commonly performed in conjunction with a major procedure would be consolidated for payment purposes. Standards would be established for including pre- and post-procedure services in global fee packages. Similar procedures could be grouped under a single category for payment purposes if the procedures are similar in terms of resource requirements. The Secretary would be required to consult with appropriate national medical specialty societies in developing standards and definitions. The Secretary would be required to complete the uniform list by July 1, 1989.

(b) Capacity to Set Geographic Payment Limits--The Secretary would be required to develop the capability to implement geographic limits on payments and charges based on statewide, regional, or national average prevailing charges beginning January 1, 1989.

(c) Expand Relative Value Study--The Secretary would be required to expand the RVS study to include the following medical specialties: cardiology, gastroenterology, hematology/oncology, pulmonary medicine, nephrology, neurology, neurosurgery, nuclear medicine, radiation therapy, plastic surgery, emergency medicine, and physical medicine and rehabilitation. If necessary, the Secretary should provide for a supplemental report concerning these specialties to ensure that the study currently in progress is submitted to Congress on time. The supplemental report would be due no later than October 1, 1989. The Secretary would be required to submit a copy of the contractor's report on the RVS and relevant supporting data to the Physician Payment Review Commission no later 30 days after the contractor's report is received by the Secretary.

(d) Civil Penalties for Unassigned Lab Services--To ensure that providers comply with the current law requirement that assignment be accepted for clinical diagnostic laboratory services, providers who knowingly and willfully violate the assignment requirement on a repeated basis would be subject to civil monetary penalties of up to \$2,000 and/or exclusion from Medicare.

(e) Revise MAAC Limits--A physician without an actual charge for a procedure during the April - June 1984 base period could submit documentation to the Medicare carrier to show that the physician had an established charge for the procedure prior to June 30, 1984. Charges made to individuals not covered by Medicare could be used for this purpose. If the carrier agrees that the physician had an established charge prior to June 30, 1984, the physician's MAAC would be based on this charge. The purpose is to prevent unintended "roll-backs" in charge limits. MAACs would apply as a flat limit. If a physician knowingly and willfully bills charges on a repeated basis amounts in excess of the applicable MAAC, the physician would be subject to civil monetary penalties or exclusion from Medicare.

(f) Prompt Submission of Data by HCFA--The Secretary would be required to submit B-MADS data for a year to Physician Payment Review Commission (PPRC), the Congressional Budget Office (CBO), and the Congressional Research Service (CRS) no later than 9 months after the close of the year. To ensure that data is available on a timely basis, the Secretary would be required to establish carrier performance evaluation standards for preparation and submission of B-MADS data. Carriers would be required to submit data that meets the applicable standards no later than 6 months after the close of the year. The Secretary, in consultation with PPRC and CBO would establish and revise standards for B-MADS data on an annual basis. The Secretary would be required to provide PPRC, CBO, and CRS with additional data as may be reasonably requested on an agreed-upon schedule.

(g) Physician Payment Studies--The Secretary would be required to conduct a several studies related to physician payment. The studies concern: (i) technical issues related to implementation of fee schedule for physician payment; (ii) issues related volume and intensity of physician's services; (iii) variations in carrier payment practices, particularly with respect to bundling of payment for related procedures; (iv) alternative definitions for office and hospital visits; (v) out-of-pocket costs for physicians' services.

The Physician Payment Review Commission would be required to conduct a study of geographic variations in approved charges or prevailing charges. The Commission would be required to develop policy recommendations for reducing unjustified variations in payment levels. The report would be due no later than March 1, 1988.

(h) Apply Prompt-Pay Interest Requirement to Rehabilitation Facilities--Authorizes payment of interest to Comprehensive Outpatient Rehabilitation Facilities, rehabilitation agencies, and other Part B providers paid by intermediaries.

(g) Technical Part B Amendments--A number of drafting errors in current law would be corrected.

Effective Date

Paragraphs (d) and (e) are effective January 1, 1988. Other paragraphs are effective on enactment.

Budget Effect

Authorized program; does not count toward reconciliation totals.

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
5	0	0	5

21. VOLUNTARY STATE HEALTH INSURANCE RISK POOLS

Present Law

Under current law states are not required to establish health insurance pools for the purpose of offering health insurance to people who are otherwise unable to purchase health insurance.

Beginning in 1974 states have enacted laws establishing comprehensive health insurance pools. These states are: Connecticut, Florida, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oregon, Tennessee, Washington and Wisconsin.

Each state insurance pool is an independent nonprofit corporation governed by a board and administered by an insurance carrier selected by the board.

In all but Connecticut, which allows all residents to buy insurance from the pool, residents in the other states must be rejected for coverage by at least one private health insurance company in order to qualify for purchase of pool insurance.

The states have generally chosen to tax contracts or policies of insurance sold to employee benefit plans (or insurance companies that sell employers such contracts or policies) to pay for losses to the pool. This has created an impression of unfairness, i.e., that only those employers that chose to provide health insurance through State regulated commercial insurers can be required to help fund risk pool shortfalls. Under this approach, employers with ERISA self-funded health benefit plans are immune from taxation. Illinois, alone, has chosen to fund pool losses through general revenues.

Explanation of Provision

States would be encouraged to voluntarily establish health insurance risk pools.

Once a state establishes a health insurance risk pool that meets the statutory criteria, any employer doing business in the state, with 20 or more employees, whether or not it provides insurance for its employees or has an ERISA self-funded plan would have to participate in the pool or be subject to a Federal tax.

To the extent that there are losses in a State pool, the losses would be assessed equitably among all participating employers in the State. Any employer that does not voluntarily participate in sharing the losses in a risk pool would be subject to the imposition of a Federal tax equal to 5 percent of gross wages (as defined in the Internal Revenue Code Sec. 3401) paid or incurred during the taxable year. If a state does not create a health insurance risk pool, there would be no tax on employers in that state.

All residents of a state with a pool who are not eligible for Medicare or Medicaid would be eligible to purchase health insurance from the risk pool.

A State risk pool would charge a premium based upon the reasonable actuarial projection of anticipated use of health services and expenses. The premium rate would be expected to ensure that the pool is self-supporting but in no event could it be higher than 150 percent of the average premium rates for individual standard risk policies for comparable coverage sold in the state.

The insurance policies offered under the state risk pool would be designed to offer coverage typical of large employer plans except that: (1) out-of-pocket limits would be \$2,000 for individuals and \$4,000 for families, (2) there could be a choice of deductibles but no deductible could exceed \$1,000 per covered individual, (3) exclusion of coverage for preexisting conditions could not be for more than 6 months, (4) lifetime limits on benefits could not be less than \$500,000, and (5) the purchase and repair of durable medical equipment would be covered.

Existing state health insurance risk pools would be allowed to maintain all of their current policies. Any State that chooses to operate a pool under this provision would have to comply with all of the requirements set forth in this provision.

All church plans (within the meaning of section 414(e) of the Internal Revenue Code) would be exempted from participating in state health insurance risk pools.

Effective Date

The proposal would be effective for taxable years after a state had established a risk pool in compliance with the provisions in the proposal.

Budget Effect

<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>3 yr</u>
0	0	0	0

